

107TH CONGRESS  
1ST SESSION

# S. 24

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JANUARY 22, 2001

Mr. LOTT (for Mr. SPECTER) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) SHORT TITLE.—This Act may be cited as the  
5       “Health Care Assurance Act of 2001”.

6       (b) TABLE OF CONTENTS.—The table of contents for  
7       this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—EXPANDED MEDICAID COVERAGE FOR LOW-INCOME  
INDIVIDUALS

Sec. 101. Expanded medicaid coverage for low-income individuals.

TITLE II—EXPANSION OF THE STATE CHILDREN’S HEALTH  
INSURANCE PROGRAM

Sec. 201. Increase in income eligibility.

TITLE III—EXPANDED HEALTH SERVICES FOR DISABLED  
INDIVIDUALS

Sec. 301. Coverage of community-based attendant services and supports under  
the medicaid program.

Sec. 302. Grants to develop and establish real choice systems change initiatives.

Sec. 303. State option for eligibility for individuals.

Sec. 304. Studies and reports.

Sec. 305. Task force on financing of long-term care services.

TITLE IV—HEALTH CARE INSURANCE COVERAGE

Subtitle A—General Provisions

Sec. 401. Amendments to the Employee Retirement Income Security Act of  
1974.

Sec. 402. Amendments to the Public Health Service Act relating to the group  
market.

Sec. 403. Amendment to the Public Health Service Act relating to the indi-  
vidual market.

Sec. 404. Effective date.

Subtitle B—Tax Provisions

Sec. 411. Enforcement with respect to health insurance issuers.

Sec. 412. Enforcement with respect to small employers.

Sec. 413. Enforcement by excise tax on qualified associations.

Sec. 414. Deduction for health insurance costs of self-employed individuals.

Sec. 415. Amendments to COBRA.

TITLE V—PRIMARY AND PREVENTIVE CARE SERVICES

Sec. 501. Improvement of medicare preventive care services.

Sec. 502. Authorization of appropriations for healthy start program.

Sec. 503. Reauthorization of certain programs providing primary and preven-  
tive care.

Sec. 504. Comprehensive school health education program.

Sec. 505. Comprehensive early childhood health education program.

Sec. 506. Adolescent family life and abstinence.

TITLE VI—PATIENT’S RIGHT TO DECLINE MEDICAL TREATMENT

Sec. 601. Patient’s right to decline medical treatment.

TITLE VII—PRIMARY AND PREVENTIVE CARE PROVIDERS

- Sec. 701. Increased medicare reimbursement for physician assistants, nurse practitioners, and clinical nurse specialists.
- Sec. 702. Requiring coverage of certain nonphysician providers under the medicaid program.
- Sec. 703. Medical student tutorial program grants.
- Sec. 704. General medical practice grants.

#### TITLE VIII—SAFE AND COST-EFFECTIVE MEDICAL TREATMENT

- Sec. 801. Enhancing investment in cost-effective methods of health care.
- Sec. 802. Medical Errors Reduction.

#### TITLE IX—TAX INCENTIVES FOR PURCHASE OF QUALIFIED LONG-TERM CARE INSURANCE

- Sec. 901. Credit for qualified long-term care premiums.
- Sec. 902. Inclusion of qualified long-term care insurance in cafeteria plans and flexible spending arrangements.
- Sec. 903. Exclusion from gross income for amounts received on cancellation of life insurance policies and used for qualified long-term care insurance contracts.
- Sec. 904. Use of gain from sale of principal residence for purchase of qualified long-term health care insurance.

#### TITLE X—NATIONAL FUND FOR HEALTH RESEARCH

- Sec. 1001. Establishment of Fund.

## **1 TITLE I—EXPANDED MEDICAID 2 COVERAGE FOR LOW-INCOME 3 INDIVIDUALS**

### **4 SEC. 101. EXPANDED MEDICAID COVERAGE FOR LOW-IN- 5 COME INDIVIDUALS.**

6 (a) REQUIRED COVERAGE OF INDIVIDUALS UP TO  
7 133 PERCENT OF POVERTY.—Section 1902(a)(10)(A)(i)  
8 of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i))  
9 is amended—

10 (1) by striking “or” at the end of subclause  
11 (VI);

12 (2) by inserting “or” after the semicolon at the  
13 end of subclause (VII); and

1 (3) by adding at the end the following:

2 “(VIII) whose family income does  
3 not exceed 133 percent of the income  
4 official poverty line (as defined by the  
5 Office of Management and Budget,  
6 and revised annually in accordance  
7 with section 673(2) of the Omnibus  
8 Budget Reconciliation Act of 1981)  
9 applicable to a family of the size in-  
10 volved;”.

11 (b) OPTIONAL COVERAGE OF INDIVIDUALS UP TO  
12 200 PERCENT OF POVERTY.—Section  
13 1902(a)(10)(A)(i)(VIII) of the Social Security Act, as  
14 added by subsection (a)(3), is amended by inserting “(200  
15 percent, at State option)” after “133 percent”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The amendments made by  
18 this section take effect on October 1, 2001.

19 (2) EXTENSION IF STATE LAW AMENDMENT  
20 REQUIRED.—In the case of a State plan under title  
21 XIX of the Social Security Act which the Secretary  
22 of Health and Human Services determines requires  
23 State legislation in order for the plan to meet the  
24 additional requirements imposed by the amendments  
25 made by this section, the State plan shall not be re-

1       garded as failing to comply with the requirements of  
 2       such title solely on the basis of its failure to meet  
 3       these additional requirements before the first day of  
 4       the first calendar quarter beginning after the close  
 5       of the first regular session of the State legislature  
 6       that begins after the date of the enactment of this  
 7       Act. For purposes of the previous sentence, in the  
 8       case of a State that has a 2-year legislative session,  
 9       each year of the session is considered to be a sepa-  
 10      rate regular session of the State legislature.

11   **TITLE II—EXPANSION OF THE**  
 12       **STATE CHILDREN’S HEALTH**  
 13       **INSURANCE PROGRAM**

14   **SEC. 201. INCREASE IN INCOME ELIGIBILITY.**

15       (a) DEFINITION OF LOW-INCOME CHILD.—Section  
 16   2110(c)(4) of the Social Security Act (42 U.S.C. 42  
 17   U.S.C. 1397jj(c)(4)) is amended by striking “200” and  
 18   inserting “235”.

19       (b) EFFECTIVE DATE.—The amendment made by  
 20   subsection (a) takes effect on October 1, 2001.

1 **TITLE III—EXPANDED HEALTH**  
 2 **SERVICES FOR DISABLED IN-**  
 3 **DIVIDUALS**

4 **SEC. 301. COVERAGE OF COMMUNITY ATTENDANT SERV-**  
 5 **ICES AND SUPPORTS UNDER THE MEDICAID**  
 6 **PROGRAM.**

7 (a) REQUIRED COVERAGE FOR INDIVIDUALS ENTI-  
 8 TLED TO NURSING FACILITY SERVICES OR ELIGIBLE FOR  
 9 INTERMEDIATE CARE FACILITY SERVICES FOR THE MEN-  
 10 TALLY RETARDED.—Section 1902(a)(10)(D) of the Social  
 11 Security Act (42 U.S.C. 1396a(a)(10)(D)) is amended—

- 12 (1) by inserting “(i)” after “(D)”;  
 13 (2) by adding “and” after the semicolon; and  
 14 (3) by adding at the end the following:

15 “(ii) subject to section 1935, for the inclu-  
 16 sion of community attendant services and sup-  
 17 ports for any individual who is eligible for med-  
 18 ical assistance under the State plan and with  
 19 respect to whom there has been a determination  
 20 that the individual requires the level of care  
 21 provided in a nursing facility or an intermediate  
 22 care facility for the mentally retarded (whether  
 23 or not coverage of such intermediate care facil-  
 24 ity is provided under the State plan) and who  
 25 requires such community attendant services and

1 supports based on functional need and without  
 2 regard to age or disability;”.

3 (b) MEDICAID COVERAGE OF COMMUNITY ATTEND-  
 4 ANT SERVICES AND SUPPORTS.—

5 (1) IN GENERAL.—Title XIX of the Social Se-  
 6 curity Act (42 U.S.C. 1396 et seq.) is amended—

7 (A) by redesignating section 1935 as sec-  
 8 tion 1936; and

9 (B) by inserting after section 1934 the fol-  
 10 lowing:

11 “COMMUNITY ATTENDANT SERVICES AND SUPPORTS

12 “SEC. 1935. (a) DEFINITIONS.—In this title:

13 “(1) COMMUNITY ATTENDANT SERVICES AND  
 14 SUPPORTS.—

15 “(A) IN GENERAL.—The term ‘community  
 16 attendant services and supports’ means attend-  
 17 ant services and supports furnished to an indi-  
 18 vidual, as needed, to assist in accomplishing ac-  
 19 tivities of daily living, instrumental activities of  
 20 daily living, and health-related functions  
 21 through hands-on assistance, supervision, or  
 22 cueing—

23 “(i) under a plan of services and sup-  
 24 ports that is based on an assessment of  
 25 functional need and that is agreed to by

the individual or, as appropriate, the individual's representative;

“(ii) in a home or community setting, which may include a school, workplace, or recreation or religious facility, but does not include a nursing facility, an intermediate care facility for the mentally retarded, or other congregate facility;

“(iii) under an agency-provider model or other model (as defined in paragraph (2)(C)); and

“(iv) the furnishing of which is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative.

“(B) INCLUDED SERVICES AND SUPPORTS.—Such term includes—

“(i) tasks necessary to assist an individual in accomplishing activities of daily living, instrumental activities of daily living, and health-related functions;

“(ii) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily liv-



ing, instrumental activities of daily living,  
and health-related functions;

“(iii) backup systems or mechanisms  
(such as the use of beepers) to ensure con-  
tinuity of services and supports; and

“(iv) voluntary training on how to se-  
lect, manage, and dismiss attendants.

“(C) EXCLUDED SERVICES AND SUP-  
PORTS.—Subject to subparagraph (D), such  
term does not include—

“(i) provision of room and board for  
the individual;

“(ii) special education and related  
services provided under the Individuals  
with Disabilities Education Act and voca-  
tional rehabilitation services provided  
under the Rehabilitation Act of 1973;

“(iii) assistive technology devices and  
assistive technology services;

“(iv) durable medical equipment; or

“(v) home modifications.

“(D) FLEXIBILITY IN TRANSITION TO  
COMMUNITY-BASED HOME SETTING.—Such  
term may include expenditures for transitional  
costs, such as rent and utility deposits, first

1 months's rent and utilities, bedding, basic  
 2 kitchen supplies, and other necessities required  
 3 for an individual to make the transition from a  
 4 nursing facility or intermediate care facility for  
 5 the mentally retarded to a community-based  
 6 home setting where the individual resides.

7 “(2) ADDITIONAL DEFINITIONS.—

8 “(A) ACTIVITIES OF DAILY LIVING.—The  
 9 term ‘activities of daily living’ includes eating,  
 10 toileting, grooming, dressing, bathing, and  
 11 transferring.

12 “(B) CONSUMER DIRECTED.—The term  
 13 ‘consumer directed’ means a method of pro-  
 14 viding services and supports that allow the indi-  
 15 vidual, or where appropriate, the individual’s  
 16 representative, maximum control of the commu-  
 17 nity attendant services and supports, regardless  
 18 of who acts as the employer of record.

19 “(C) DELIVERY MODELS.—

20 “(i) AGENCY-PROVIDER MODEL.—The  
 21 term ‘agency-provider model’ means, with  
 22 respect to the provision of community at-  
 23 tendant services and supports for an indi-  
 24 vidual, a method of providing consumer-di-  
 25 rected services and supports under which

1 entities contract for the provision of such  
2 services and supports.

3 “(ii) OTHER MODELS.—The term  
4 ‘other models’ means methods, other than  
5 an agency-provider model, for the provision  
6 of consumer-directed services and supports.  
7 Such models may include the provision of  
8 vouchers, direct cash payments, or use of  
9 a fiscal agent to assist in obtaining serv-  
10 ices.

11 “(D) HEALTH-RELATED FUNCTIONS.—The  
12 term ‘health-related functions’ means functions  
13 that can be delegated or assigned by licensed  
14 health-care professionals under State law to be  
15 performed by an attendant.

16 “(E) INSTRUMENTAL ACTIVITIES OF DAILY  
17 LIVING.—The term ‘instrumental activities of  
18 daily living’ includes meal planning and prepa-  
19 ration, managing finances, shopping for food,  
20 clothing and other essential items, performing  
21 essential household chores, communicating by  
22 phone and other media, and getting around and  
23 participating in the community.

24 “(F) INDIVIDUAL’S REPRESENTATIVE.—  
25 The term ‘individual’s representative’ means a

1           parent, a family member, a guardian, an advo-  
2           cate, or an authorized representative of an indi-  
3           vidual.

4           “(b) LIMITATION ON AMOUNTS OF EXPENDITURES  
5 UNDER THIS TITLE.—In carrying out section  
6 1902(a)(10)(D)(ii), a State shall permit an individual who  
7 has a level of severity of physical or mental impairment  
8 that entitles such individual to medical assistance with re-  
9 spect to nursing facility services or qualifies the individual  
10 for intermediate care facility services for the mentally re-  
11 tarder to choose to receive medical assistance for commu-  
12 nity attendant services and supports (rather than medical  
13 assistance for such institutional services and supports), in  
14 the most integrated setting appropriate to the needs of  
15 the individual, so long as the aggregate amount of the  
16 Federal expenditures for community attendant services  
17 and supports for all such individuals in a fiscal year does  
18 not exceed the total that would have been expended for  
19 such individuals to receive such institutional services and  
20 supports in the year.

21           “(c) MAINTENANCE OF EFFORT.—With respect to a  
22 fiscal year quarter, no Federal funds may be paid to a  
23 State for medical assistance provided to individuals de-  
24 scribed in section 1902(a)(10)(D)(ii) for such fiscal year  
25 quarter if the Secretary determines that the total of the

1 State expenditures for programs to enable such individuals  
 2 with disabilities to receive community attendant services  
 3 and supports (or services and supports that are similar  
 4 to such services and supports) under other provisions of  
 5 this title for the preceding fiscal year quarter is less than  
 6 the total of such expenditures for the same fiscal year  
 7 quarter for the preceding fiscal year.

8 “(d) STATE QUALITY ASSURANCE PROGRAM.—In  
 9 order to continue to receive Federal financial participation  
 10 for providing community attendant services and supports  
 11 under this section, a State shall, at a minimum, establish  
 12 and maintain a quality assurance program that provides  
 13 for the following:

14 “(1) The State shall establish requirements, as  
 15 appropriate, for agency-based and other models that  
 16 include—

17 “(A) minimum qualifications and training  
 18 requirements, as appropriate for agency-based  
 19 and other models;

20 “(B) financial operating standards; and

21 “(C) an appeals procedure for eligibility  
 22 denials and a procedure for resolving disagree-  
 23 ments over the terms of an individualized plan.

24 “(2) The State shall modify the quality assur-  
 25 ance program, where appropriate, to maximize con-

1 consumer independence and consumer direction in both  
2 agency-provided and other models.

3 “(3) The State shall provide a system that al-  
4 lows for the external monitoring of the quality of  
5 services by entities consisting of consumers and their  
6 representatives, disability organizations, providers,  
7 family, members of the community, and others.

8 “(4) The State provides ongoing monitoring of  
9 the health and well-being of each recipient.

10 “(5) The State shall require that quality assur-  
11 ance mechanisms appropriate for the individual  
12 should be included in the individual’s written plan.

13 “(6) The State shall establish a process for  
14 mandatory reporting, investigation, and resolution of  
15 allegations of neglect, abuse, or exploitation.

16 “(7) The State shall obtain meaningful con-  
17 sumer input, including consumer surveys, that meas-  
18 ure the extent to which a participant receives the  
19 services and supports described in the individual’s  
20 plan and the participant’s satisfaction with such  
21 services and supports.

22 “(8) The State shall make available to the pub-  
23 lic the findings of the quality assurance program.

1           “(9) The State shall establish an on-going pub-  
 2       lic process for the development, implementation, and  
 3       review of the State’s quality assurance program.

4           “(10) The State shall develop and implement a  
 5       program of sanctions.

6       “(e) FEDERAL ROLE IN QUALITY ASSURANCE.—The  
 7       Secretary shall conduct a periodic sample review of out-  
 8       comes for individuals based upon the individual’s plan of  
 9       support and based upon the quality assurance program of  
 10      the State. The Secretary may conduct targeted reviews  
 11      upon receipt of allegations of neglect, abuse, or exploi-  
 12      tation. The Secretary shall develop guidelines for States  
 13      to use in developing sanctions.

14       “(f) REQUIREMENT TO EXPAND ELIGIBILITY.—Ef-  
 15      fective October 1, 2002, a State may not exercise the op-  
 16      tion of coverage of individuals under section  
 17      1902(a)(10)(A)(ii)(V) without providing coverage under  
 18      section 1902(a)(10)(A)(ii)(VI).

19       “(g) REPORT ON IMPACT OF SECTION.—The Sec-  
 20      retary shall submit to Congress periodic reports on the  
 21      impact of this section on beneficiaries, States, and the  
 22      Federal Government.”.

23       “(c) INCLUSION IN OPTIONAL ELIGIBILITY CLASSI-  
 24      FICATION.—Section 1902(a)(10)(A)(ii)(VI) of the Social  
 25      Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is

1 amended by inserting “or community attendant services  
 2 and supports described in section 1935” after “section  
 3 1915” each place such term appears.

4 (d) COVERAGE AS MEDICAL ASSISTANCE.—

5 (1) IN GENERAL.—Section 1905(a) of the So-  
 6 cial Security Act (42 U.S.C. 1396d) is amended—

7 (A) by striking “and” at the end of para-  
 8 graph (26);

9 (B) by redesignating paragraph (27) as  
 10 paragraph (28); and

11 (C) by inserting after paragraph (26) the  
 12 following:

13 “(27) community attendant services and sup-  
 14 ports (to the extent allowed and as defined in section  
 15 1935); and”.

16 (2) CONFORMING AMENDMENT.—Section  
 17 1902(a)(10)(C)(iv) of the Social Security Act (42  
 18 U.S.C. 1396a(a)(10)(C)(iv)) is amended by inserting  
 19 “and (27)” after “(24)”.

20 (e) EFFECTIVE DATE.—The amendments made by  
 21 this section take effect on October 1, 2001, and apply to  
 22 medical assistance provided under title XIX of the Social  
 23 Security Act (42 U.S.C. 1396 et seq.) on or after that  
 24 date.



1 **SEC. 302. GRANTS TO DEVELOP AND ESTABLISH REAL**  
2 **CHOICE SYSTEMS CHANGE INITIATIVES.**

3 (a) ESTABLISHMENT.—

4 (1) IN GENERAL.—The Secretary of Health and  
5 Human Services (referred to in this section as the  
6 “Secretary”) shall award grants described in sub-  
7 section (b) to States for a fiscal year to support real  
8 choice systems change initiatives that establish spe-  
9 cific action steps and specific timetables to provide  
10 consumer-responsive long term services and supports  
11 to eligible individuals in the most integrated setting  
12 appropriate based on the unique strengths and needs  
13 of the individual and the priorities and concerns of  
14 the individual (or, as appropriate, the individual’s  
15 representative).

16 (2) ELIGIBILITY.—To be eligible for a grant  
17 under this section, a State shall—

18 (A) establish the Consumer Task Force in  
19 accordance with subsection (d); and

20 (B) submit an application at such time, in  
21 such manner, and containing such information  
22 as the Secretary may determine. The applica-  
23 tion shall be jointly developed and signed by the  
24 designated State official and the chairperson of  
25 such Task Force, acting on behalf of and at the  
26 direction of the Task Force.

1           (3) DEFINITION OF STATE.—In this section,  
 2           the term “State” means each of the 50 States, the  
 3           District of Columbia, Puerto Rico, Guam, the  
 4           United States Virgin Islands, American Samoa, and  
 5           the Commonwealth of the Northern Mariana Is-  
 6           lands.

7           (b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE  
 8 INITIATIVES.—

9           (1) IN GENERAL.—From funds appropriated  
 10          under subsection (g), the Secretary shall award  
 11          grants to States for a fiscal year to—

12                 (A) support the establishment, implemen-  
 13                 tation, and operation of the State real choice  
 14                 systems change initiatives described in sub-  
 15                 section (a); and

16                 (B) conduct outreach campaigns regarding  
 17                 the existence of such initiatives.

18           (2) DETERMINATION OF AWARDS; STATE AL-  
 19          LOTMENTS.—The Secretary shall develop a formula  
 20          for the distribution of funds to States for each fiscal  
 21          year under subsection (a). Such formula shall give  
 22          preference to States that have a relatively higher  
 23          proportion of long-term services and supports fur-  
 24          nished to individuals in an institutional setting but

1       who have a plan described in an application sub-  
2       mitted under subsection (a)(2).

3       (c) AUTHORIZED ACTIVITIES.—A State that receives  
4       a grant under this section shall use the funds made avail-  
5       able through the grant to accomplish the purposes de-  
6       scribed in subsection (a) and, in accomplishing such pur-  
7       poses, may carry out any of the following systems change  
8       activities:

9               (1) NEEDS ASSESSMENT AND DATA GATH-  
10       ERING.—The State may use funds to conduct a  
11       statewide needs assessment that may be based on  
12       data in existence on the date on which the assess-  
13       ment is initiated and may include information about  
14       the number of individuals within the State who are  
15       receiving long-term services and supports in unnec-  
16       essarily segregated settings, the nature and extent to  
17       which current programs respond to the preferences  
18       of individuals with disabilities to receive services in  
19       home and community-based settings as well as in in-  
20       stitutional settings, and the expected change in de-  
21       mand for services provided in home and community  
22       settings as well as institutional settings.

23               (2) INSTITUTIONAL BIAS.—The State may use  
24       funds to identify, develop, and implement strategies  
25       for modifying policies, practices, and procedures that

1 unnecessarily bias the provision of long-term services  
 2 and supports toward institutional settings and away  
 3 from home and community-based settings, including  
 4 policies, practices, and procedures governing  
 5 statewideness, comparability in amount, duration,  
 6 and scope of services, financial eligibility, individual-  
 7 ized functional assessments and screenings (includ-  
 8 ing individual and family involvement), and knowl-  
 9 edge about service options.

10 (3) OVER MEDICALIZATION OF SERVICES.—The  
 11 State may use funds to identify, develop, and imple-  
 12 ment strategies for modifying policies, practices, and  
 13 procedures that unnecessarily bias the provision of  
 14 long-term services and supports by health care pro-  
 15 fessionals to the extent that quality services and  
 16 supports can be provided by other qualified individ-  
 17 uals, including policies, practices, and procedures  
 18 governing service authorization, case management,  
 19 and service coordination, service delivery options,  
 20 quality controls, and supervision and training.

21 (4) INTERAGENCY COORDINATION; SINGLE  
 22 POINT OF ENTRY.—The State may support activities  
 23 to identify and coordinate Federal and State poli-  
 24 cies, resources, and services, relating to the provision  
 25 of long-term services and supports, including the

1 convening of interagency work groups and the enter-  
2 ing into of interagency agreements that provide for  
3 a single point of entry and the design and implemen-  
4 tation of a coordinated screening and assessment  
5 system for all persons eligible for long-term services  
6 and supports.

7 (5) TRAINING AND TECHNICAL ASSISTANCE.—

8 The State may carry out directly, or may provide  
9 support to a public or private entity to carry out  
10 training and technical assistance activities that are  
11 provided for individuals with disabilities, and, as ap-  
12 propriate, their representatives, attendants, and  
13 other personnel (including professionals, paraprofes-  
14 sionals, volunteers, and other members of the com-  
15 munity).

16 (6) PUBLIC AWARENESS.—The State may sup-

17 port a public awareness program that is designed to  
18 provide information relating to the availability of  
19 choices available to individuals with disabilities for  
20 receiving long-term services and support in the most  
21 integrated setting appropriate.

22 (7) DOWNSIZING OF LARGE INSTITUTIONS.—

23 The State may use funds to support the per capita  
24 increased fixed costs in institutional settings directly  
25 related to the movement of individuals with disabil-

1       ities out of specific facilities and into community-  
2       based settings.

3               (8) TRANSITIONAL COSTS.—The State may use  
4       funds to provide transitional costs described in sec-  
5       tion 1935(a)(1)(D) of the Social Security Act, as  
6       added by section 301(b) of this Act.

7               (9) TASK FORCE.—The State may use funds to  
8       support the operation of the Consumer Task Force  
9       established under subsection (d).

10              (10) DEMONSTRATIONS OF NEW AP-  
11       PROACHES.—The State may use funds to conduct,  
12       on a time-limited basis, the demonstration of new  
13       approaches to accomplishing the purposes described  
14       in subsection (a).

15              (11) OTHER ACTIVITIES.—The State may use  
16       funds for any systems change activities that are not  
17       described in any of the preceding paragraphs of this  
18       subsection and that are necessary for developing, im-  
19       plementing, or evaluating the comprehensive state-  
20       wide system of long term services and supports.

21       (d) CONSUMER TASK FORCE.—

22              (1) ESTABLISHMENT AND DUTIES.—To be eli-  
23       gible to receive a grant under this section, each  
24       State shall establish a Consumer Task Force (re-  
25       ferred to in this section as the “Task Force”) to as-

1       sist the State in the development, implementation,  
 2       and evaluation of real choice systems change initia-  
 3       tives.

4           (2) APPOINTMENT.—Members of the Task  
 5       Force shall be appointed by the Chief Executive Of-  
 6       ficer of the State in accordance with the require-  
 7       ments of paragraph (3), after the solicitation of rec-  
 8       ommendations from representatives of organizations  
 9       representing a broad range of individuals with dis-  
 10      abilities and organizations interested in individuals  
 11      with disabilities.

12          (3) COMPOSITION.—

13           (A) IN GENERAL.—The Task Force shall  
 14       represent a broad range of individuals with dis-  
 15       abilities from diverse backgrounds and shall in-  
 16       clude representatives from Developmental Dis-  
 17       abilities Councils, State Independent Living  
 18       Councils, Commissions on Aging, organizations  
 19       that provide services to individuals with disabil-  
 20       ities and consumers of long-term services and  
 21       supports.

22           (B) INDIVIDUALS WITH DISABILITIES.—A  
 23       majority of the members of the Task Force  
 24       shall be individuals with disabilities or the rep-  
 25       resentatives of such individuals.

1 (C) LIMITATION.—The Task Force shall  
2 not include employees of any State agency pro-  
3 viding services to individuals with disabilities  
4 other than employees of agencies described in  
5 the Developmental Disabilities Assistance and  
6 Bill of Rights Act (42 U.S.C. 6000 et seq.).

7 (e) AVAILABILITY OF FUNDS.—

8 (1) FUNDS ALLOTTED TO STATES.—Funds al-  
9 lotted to a State under a grant made under this sec-  
10 tion for a fiscal year shall remain available until ex-  
11 pended.

12 (2) FUNDS NOT ALLOTTED TO STATES.—Funds  
13 not allotted to States in the fiscal year for which  
14 they are appropriated shall remain available in suc-  
15 ceeding fiscal years for allotment by the Secretary  
16 using the allotment formula established by the Sec-  
17 retary under subsection (b)(2).

18 (f) ANNUAL REPORT.—A State that receives a grant  
19 under this section shall submit an annual report to the  
20 Secretary on the use of funds provided under the grant.  
21 Each report shall include the percentage increase in the  
22 number of eligible individuals in the State who receive  
23 long-term services and supports in the most integrated  
24 setting appropriate, including through community attend-



1 ant services and supports and other community-based set-  
 2 tings.

3 (g) APPROPRIATION.—Out of any funds in the Treas-  
 4 ury not otherwise appropriated, there is authorized to be  
 5 appropriated and there is appropriated to make grants  
 6 under this section for—

7 (1) fiscal year 2002, \$25,000,000; and

8 (2) for fiscal year 2003 and each fiscal year  
 9 thereafter, such sums as may be necessary to carry  
 10 out this section.

11 **SEC. 303. STATE OPTION FOR ELIGIBILITY FOR INDIVID-**  
 12 **UALS.**

13 (a) IN GENERAL.—Section 1903(f) of the Social Se-  
 14 curity Act (42 U.S.C. 1396b(f)) is amended—

15 (1) in paragraph (4)(C), by inserting “subject  
 16 to paragraph (5),” after “does not exceed”, and

17 (2) by adding at the end the following:

18 “(5)(A) A State may waive the income, resources,  
 19 and deeming limitations described in paragraph (4)(C) in  
 20 such cases as the State finds the potential for employment  
 21 opportunities would be enhanced through the provision of  
 22 medical assistance for community attendant services and  
 23 supports in accordance with section 1935.

24 “(B) In the case of an individual who is eligible for  
 25 medical assistance described in subparagraph (A) only as

1 a result of the application of such subparagraph, the State  
2 may, notwithstanding section 1916(b), impose a premium  
3 based on a sliding scale related to income.”.

4 (b) EFFECTIVE DATE.—The amendments made by  
5 subsection (a) shall apply to medical assistance provided  
6 for community attendant services and supports described  
7 in section 1935 of the Social Security Act, as added by  
8 section 301(b) of this Act, furnished on or after October  
9 1, 2001.

10 **SEC. 304. STUDIES AND REPORTS.**

11 (a) REVIEW OF, AND REPORT ON, REGULATIONS.—  
12 The National Council on Disability established under title  
13 IV of the Rehabilitation Act of 1973 (29 U.S.C. 780 et  
14 seq.) shall review regulations in existence under title XIX  
15 of the Social Security Act (42 U.S.C. 1396 et seq.) on  
16 the date of enactment of this Act insofar as such regula-  
17 tions regulate the provision of home health services, per-  
18 sonal care services, and other services in home and com-  
19 munity-based settings and, not later than 1 year after  
20 such date, submit a report to Congress on the results of  
21 such study, together with any recommendations for legis-  
22 lation that the Council determines to be appropriate as  
23 a result of the study.

24 (b) REPORT ON REDUCED TITLE XIX EXPENDI-  
25 TURES.—Not later than 1 year after the date of enact-

1 ment of this Act, the Secretary of Health and Human  
 2 Services shall submit to Congress a report on how expendi-  
 3 tures under the medicaid program under title XIX of the  
 4 Social Security Act (42 U.S.C. 1396 et seq.) can be re-  
 5 duced by the furnishing of community attendant services  
 6 and supports in accordance with section 1935 of the Social  
 7 Security Act (as added by section 301(b) of this Act).

8 **SEC. 305. TASK FORCE ON FINANCING OF LONG-TERM**  
 9 **CARE SERVICES.**

10 The Secretary of Health and Human Services shall  
 11 establish a task force to examine appropriate methods for  
 12 financing long-term services and supports. The task force  
 13 shall include significant representation of individuals (and  
 14 representatives of individuals) who receive such services  
 15 and supports.

16 **TITLE IV—HEALTH CARE**  
 17 **INSURANCE COVERAGE**  
 18 **Subtitle A—General Provisions**

19 **SEC. 401. AMENDMENTS TO THE EMPLOYEE RETIREMENT**  
 20 **INCOME SECURITY ACT OF 1974.**

21 (a) IN GENERAL.—Part 7 of subtitle B of title I of  
 22 the Employee Retirement Income Security Act of 1974  
 23 (29 U.S.C. 1181 et seq.) is amended—

24 (1) by redesignating subpart C as subpart D;  
 25 and

1 (2) by inserting after subpart B, the following:

2 “SUBPART C—GENERAL INSURANCE COVERAGE

3 REFORMS

4 **“CHAPTER 1—INCREASED AVAILABILITY AND**  
 5 **CONTINUITY OF HEALTH COVERAGE**

6 **“SEC. 721. DEFINITION.**

7 “As used in this subpart, the term ‘qualified group  
 8 health plan’ means a group health plan, and a health in-  
 9 surance issuer offering group health insurance coverage,  
 10 that is designed to provide standard coverage (consistent  
 11 with section 721A(b)).

12 **“SEC. 721A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**  
 13 **MITTED.**

14 “(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

15 “(1) INITIAL DETERMINATION.—The NAIC is  
 16 requested to submit to the Secretary, within 6  
 17 months after the date of the enactment of this sub-  
 18 part, a set of rules which the NAIC determines is  
 19 sufficient for determining, in the case of any group  
 20 health plan, or a health insurance issuer offering  
 21 group health insurance coverage, and for purposes of  
 22 this section, the actuarial value of the coverage of-  
 23 fered by the plan or coverage.

24 “(2) CERTIFICATION.—If the Secretary deter-  
 25 mines that the NAIC has submitted a set of rules

1 that comply with the requirements of paragraph (1),  
 2 the Secretary shall certify such set of rules for use  
 3 under this subpart. If the Secretary determines that  
 4 such a set of rules has not been submitted or does  
 5 not comply with such requirements, the Secretary  
 6 shall promptly establish a set of rules that meets  
 7 such requirements.

8 “(b) STANDARD COVERAGE.—

9 “(1) IN GENERAL.—A group health plan, and a  
 10 health insurance issuer offering group health insur-  
 11 ance coverage, shall be considered to provide stand-  
 12 ard coverage consistent with this subsection if the  
 13 benefits are determined, in accordance with the set  
 14 of actuarial equivalence rules certified under sub-  
 15 section (a), to have a value that is within 5 percent-  
 16 age points of the target actuarial value for standard  
 17 coverage established under paragraph (2).

18 “(2) INITIAL DETERMINATION OF TARGET AC-  
 19 TUARIAL VALUE FOR STANDARD COVERAGE.—

20 “(A) INITIAL DETERMINATION.—

21 “(i) IN GENERAL.—The NAIC is re-  
 22 quested to submit to the Secretary, within  
 23 6 months after the date of the enactment  
 24 of this subpart, a target actuarial value for  
 25 standard coverage equal to the average ac-

1            actuarial value of the coverage described in  
 2            clause (ii). No specific procedure or treat-  
 3            ment, or classes thereof, is required to be  
 4            considered in such determination by this  
 5            subpart or through regulations. The deter-  
 6            mination of such value shall be based on a  
 7            representative distribution of the popu-  
 8            lation of eligible employees offered such  
 9            coverage and a single set of standardized  
 10          utilization and cost factors.

11           “(ii) COVERAGE DESCRIBED.—The  
 12          coverage described in this clause is cov-  
 13          erage for medically necessary and appro-  
 14          priate services consisting of medical and  
 15          surgical services, medical equipment, pre-  
 16          ventive services, and emergency transpor-  
 17          tation in frontier areas. No specific proce-  
 18          dure or treatment, or classes thereof, is re-  
 19          quired to be covered in such a plan, by this  
 20          subpart or through regulations.

21           “(B) CERTIFICATION.—If the Secretary  
 22          determines that the NAIC has submitted a tar-  
 23          get actuarial value for standard coverage that  
 24          complies with the requirements of subparagraph  
 25          (A), the Secretary shall certify such value for

1           use under this chapter. If the Secretary deter-  
2           mines that a target actuarial value has not been  
3           submitted or does not comply with the require-  
4           ments of subparagraph (A), the Secretary shall  
5           promptly determine a target actuarial value  
6           that meets such requirements.

7           “(c) SUBSEQUENT REVISIONS.—

8           “(1) NAIC.—The NAIC may submit from time  
9           to time to the Secretary revisions of the set of rules  
10          of actuarial equivalence and target actuarial values  
11          previously established or determined under this sec-  
12          tion if the NAIC determines that revisions are nec-  
13          essary to take into account changes in the relevant  
14          types of health benefits provisions or in demographic  
15          conditions which form the basis for the set of rules  
16          of actuarial equivalence or the target actuarial val-  
17          ues. The provisions of subsection (a)(2) shall apply  
18          to such a revision in the same manner as they apply  
19          to the initial determination of the set of rules.

20          “(2) SECRETARY.—The Secretary may by regu-  
21          lation revise the set of rules of actuarial equivalence  
22          and target actuarial values from time to time if the  
23          Secretary determines such revisions are necessary to  
24          take into account changes described in paragraph  
25          (1).

1 **“SEC. 721B. ESTABLISHMENT OF PLAN STANDARDS.**

2 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

3 “(1) ROLE OF NAIC.—The NAIC is requested  
4 to submit to the Secretary, within 9 months after  
5 the date of the enactment of this subpart, model  
6 regulations that specify standards for making quali-  
7 fied group health plans available to small employers.  
8 If the NAIC develops recommended regulations  
9 specifying such standards within such period, the  
10 Secretary shall review the standards. Such review  
11 shall be completed within 60 days after the date the  
12 regulations are developed. Such standards shall  
13 serve as the standards under this section, with such  
14 amendments as the Secretary deems necessary. Such  
15 standards shall be nonbinding (except as provided in  
16 chapter 4).

17 “(2) CONTINGENCY.—If the NAIC does not de-  
18 velop such model regulations within the period de-  
19 scribed in paragraph (1), the Secretary shall specify,  
20 within 15 months after the date of the enactment of  
21 this subpart, model regulations that specify stand-  
22 ards for insurers with regard to making qualified  
23 group health plans available to small employers.  
24 Such standards shall be nonbinding (except as pro-  
25 vided in chapter 4).



1           “(3) EFFECTIVE DATE.—The standards speci-  
 2           fied in the model regulations shall apply to group  
 3           health plans and health insurance issuers offering  
 4           group health insurance coverage in a State on or  
 5           after the respective date the standards are imple-  
 6           mented in the State.

7           “(b) NO PREEMPTION OF STATE LAW.—A State may  
 8           implement standards for group health plans available, and  
 9           health insurance issuers offering group health insurance  
 10          coverage offered, to small employers that are more strin-  
 11          gent than the standards under this section, except that  
 12          a State may not implement standards that prevent the of-  
 13          fering of at least one group health plan that provides  
 14          standard coverage (as described in section 721A(b)).

15       **“SEC. 721C. RATING LIMITATIONS FOR COMMUNITY-RATED**  
 16                               **MARKET.**

17          “(a) STANDARD PREMIUMS WITH RESPECT TO COM-  
 18          MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-  
 19          DIVIDUALS.—

20               “(1) IN GENERAL.—Each group health plan of-  
 21               fered, and each health insurance issuer offering  
 22               group health insurance coverage, to a small em-  
 23               ployer shall establish within each community rating  
 24               area in which the plan is to be offered, a standard  
 25               premium for enrollment of eligible employees and eli-

gible individuals for the standard coverage (as defined under section 721A(b)).

“(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

“(A) IN GENERAL.—Not later than January 1, 2002, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

“(B) GEOGRAPHIC AREA VARIATIONS.—  
For purposes of subparagraph (A), a State—

“(i) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area;

“(ii) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered; and

“(iii) may, upon agreement with one or more adjacent States, identify multi-State geographic areas consistent with clauses (i) and (ii).

1           “(3) ELIGIBLE INDIVIDUALS.—For purposes of  
 2           this section, the term ‘eligible individuals’ includes  
 3           certain uninsured individuals (as described in section  
 4           721G).

5           “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
 6           ING AREAS.—

7           “(1) IN GENERAL.—Subject to paragraphs (2)  
 8           and (3), the standard premium for each group  
 9           health plan to which this section applies shall be the  
 10          same, but shall not include the costs of premium  
 11          processing and enrollment that may vary depending  
 12          on whether the method of enrollment is through a  
 13          qualified small employer purchasing group, through  
 14          a small employer, or through a broker.

15          “(2) APPLICATION TO ENROLLEES.—

16                 “(A) IN GENERAL.—The premium charged  
 17                 for coverage in a group health plan which cov-  
 18                 ers eligible employees and eligible individuals  
 19                 shall be the product of—

20                         “(i) the standard premium (estab-  
 21                         lished under paragraph (1));

22                         “(ii) in the case of enrollment other  
 23                         than individual enrollment, the family ad-  
 24                         justment factor specified under subpara-  
 25                         graph (B); and

1 “(iii) the age adjustment factor (spec-  
 2 ified under subparagraph (C)).

3 “(B) FAMILY ADJUSTMENT FACTOR.—

4 “(i) IN GENERAL.—The standards es-  
 5 tablished under section 721B shall specify  
 6 family adjustment factors that reflect the  
 7 relative actuarial costs of benefit packages  
 8 based on family classes of enrollment (as  
 9 compared with such costs for individual en-  
 10 rollment).

11 “(ii) CLASSES OF ENROLLMENT.—For  
 12 purposes of this subpart, there are 4 class-  
 13 es of enrollment:

14 “(I) Coverage only of an indi-  
 15 vidual (referred to in this subpart as  
 16 the ‘individual’ enrollment or class of  
 17 enrollment).

18 “(II) Coverage of a married cou-  
 19 ple without children (referred to in  
 20 this subpart as the ‘couple-only’ en-  
 21 rollment or class of enrollment).

22 “(III) Coverage of an individual  
 23 and one or more children (referred to  
 24 in this subpart as the ‘single parent’  
 25 enrollment or class of enrollment).

1 “(IV) Coverage of a married cou-  
 2 ple and one or more children (referred  
 3 to in this subpart as the ‘dual parent’  
 4 enrollment or class of enrollment).

5 “(iii) REFERENCES TO FAMILY AND  
 6 COUPLE CLASSES OF ENROLLMENT.—In  
 7 this subpart:

8 “(I) FAMILY.—The terms ‘family  
 9 enrollment’ and ‘family class of enroll-  
 10 ment’ refer to enrollment in a class of  
 11 enrollment described in any subclause  
 12 of clause (ii) (other than subclause  
 13 (I)).

14 “(II) COUPLE.—The term ‘couple  
 15 class of enrollment’ refers to enroll-  
 16 ment in a class of enrollment de-  
 17 scribed in subclause (II) or (IV) of  
 18 clause (ii).

19 “(iv) SPOUSE; MARRIED; COUPLE.—

20 “(I) IN GENERAL.—In this sub-  
 21 part, the terms ‘spouse’ and ‘married’  
 22 mean, with respect to an individual,  
 23 another individual who is the spouse  
 24 of, or is married to, the individual, as

1                   determined under applicable State  
2                   law.

3                   “(II) COUPLE.—The term ‘cou-  
4                   ple’ means an individual and the indi-  
5                   vidual’s spouse.

6                   “(C) AGE ADJUSTMENT FACTOR.—The  
7                   Secretary, in consultation with the NAIC, shall  
8                   specify uniform age categories and maximum  
9                   rating increments for age adjustment factors  
10                  that reflect the relative actuarial costs of ben-  
11                  efit packages among enrollees. For individuals  
12                  who have attained age 18 but not age 65, the  
13                  highest age adjustment factor may not exceed 3  
14                  times the lowest age adjustment factor.

15                  “(3) ADMINISTRATIVE CHARGES.—

16                  “(A) IN GENERAL.—In accordance with  
17                  the standards established under section 721B, a  
18                  group health plan which covers eligible employ-  
19                  ees and eligible individuals may add a sepa-  
20                  rately-stated administrative charge which is  
21                  based on identifiable differences in legitimate  
22                  administrative costs and which is applied uni-  
23                  formly for individuals enrolling through the  
24                  same method of enrollment. Nothing in this  
25                  subparagraph may be construed as preventing a

1 qualified small employer purchasing group from  
 2 negotiating a unique administrative charge with  
 3 an insurer for a group health plan.

4 “(B) ENROLLMENT THROUGH A QUALI-  
 5 FIED SMALL EMPLOYER PURCHASING GROUP.—

6 In the case of an administrative charge under  
 7 subparagraph (A) for enrollment through a  
 8 qualified small employer purchasing group, such  
 9 charge may not exceed the lowest charge of  
 10 such plan for enrollment other than through a  
 11 qualified small employer purchasing group in  
 12 such area.

13 “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-  
 14 NITY RATE.—Notwithstanding any other provision of this  
 15 section, a group health plan and a health insurance issuer  
 16 offering health insurance coverage that negotiates a pre-  
 17 mium rate (exclusive of any administrative charge de-  
 18 scribed in subsection (b)(3)) with a qualified small em-  
 19 ployer purchasing group in a community rating area shall  
 20 charge the same premium rate to all eligible employees  
 21 and eligible individuals.

22 **“SEC. 721D. RATING PRACTICES AND PAYMENT OF PRE-**  
 23 **MIUMS.**

24 “(a) FULL DISCLOSURE OF RATING PRACTICES.—

1           “(1) IN GENERAL.—A group health plan and a  
2           health insurance issuer offering health insurance  
3           coverage shall fully disclose rating practices for the  
4           plan to the appropriate certifying authority.

5           “(2) NOTICE ON EXPIRATION.—A group health  
6           plan and a health insurance issuer offering health  
7           insurance coverage shall provide for notice of the  
8           terms for renewal of a plan at the time of the offer-  
9           ing of the plan and at least 90 days before the date  
10          of expiration of the plan.

11          “(3) ACTUARIAL CERTIFICATION.—Each group  
12          health plan and health insurance issuer offering  
13          health insurance coverage shall file annually with the  
14          appropriate certifying authority a written statement  
15          by a member of the American Academy of Actuaries  
16          (or other individual acceptable to such authority)  
17          who is not an employee of the group health plan or  
18          issuer certifying that, based upon an examination by  
19          the individual which includes a review of the appro-  
20          priate records and of the actuarial assumptions of  
21          such plan or insurer and methods used by the plan  
22          or insurer in establishing premium rates and admin-  
23          istrative charges for group health plans—



1           “(A) such plan or insurer is in compliance  
2           with the applicable provisions of this subpart;  
3           and

4           “(B) the rating methods are actuarially  
5           sound.

6           Each plan and insurer shall retain a copy of such  
7           statement at its principal place of business for exam-  
8           ination by any individual.

9           “(b) PAYMENT OF PREMIUMS.—

10           “(1) IN GENERAL.—With respect to a new en-  
11           rollee in a group health plan, the plan may require  
12           advanced payment of an amount equal to the month-  
13           ly applicable premium for the plan at the time such  
14           individual is enrolled.

15           “(2) NOTIFICATION OF FAILURE TO RECEIVE  
16           PREMIUM.—If a group health plan or a health insur-  
17           ance issuer offering health insurance coverage fails  
18           to receive payment on a premium due with respect  
19           to an eligible employee or eligible individual covered  
20           under the plan involved, the plan or issuer shall pro-  
21           vide notice of such failure to the employee or indi-  
22           vidual within the 20-day period after the date on  
23           which such premium payment was due. A plan or  
24           issuer may not terminate the enrollment of an eligi-  
25           ble employee or eligible individual unless such em-

1        ployee or individual has been notified of any overdue  
 2        premiums and has been provided a reasonable op-  
 3        portunity to respond to such notice.

4    **“SEC. 721E. QUALIFIED SMALL EMPLOYER PURCHASING**  
 5        **GROUPS.**

6        “(a) QUALIFIED SMALL EMPLOYER PURCHASING  
 7    GROUPS DESCRIBED.—

8                “(1) IN GENERAL.—A qualified small employer  
 9        purchasing group is an entity that—

10                “(A) is a nonprofit entity certified under  
 11        State law;

12                “(B) has a membership consisting solely of  
 13        small employers;

14                “(C) is administered solely under the au-  
 15        thority and control of its member employers;

16                “(D) with respect to each State in which  
 17        its members are located, consists of not fewer  
 18        than the number of small employers established  
 19        by the State as appropriate for such a group;

20                “(E) offers a program under which quali-  
 21        fied group health plans are offered to eligible  
 22        employees and eligible individuals through its  
 23        member employers and to certain uninsured in-  
 24        dividuals in accordance with section 721D; and

1           “(F) an insurer, agent, broker, or any  
 2           other individual or entity engaged in the sale of  
 3           insurance—

4           “(i) does not form or underwrite; and

5           “(ii) does not hold or control any  
 6           right to vote with respect to.

7           “(2) STATE CERTIFICATION.—A qualified small  
 8           employer purchasing group formed under this sec-  
 9           tion shall submit an application to the State for cer-  
 10          tification. The State shall determine whether to  
 11          issue a certification and otherwise ensure compliance  
 12          with the requirements of this subpart.

13          “(3) SPECIAL RULE.—Notwithstanding para-  
 14          graph (1)(B), an employer member of a small em-  
 15          ployer purchasing group that has been certified by  
 16          the State as meeting the requirements of paragraph  
 17          (1) may retain its membership in the group if the  
 18          number of employees of the employer increases such  
 19          that the employer is no longer a small employer.

20          “(b) BOARD OF DIRECTORS.—Each qualified small  
 21          employer purchasing group established under this section  
 22          shall be governed by a board of directors or have active  
 23          input from an advisory board consisting of individuals and  
 24          businesses participating in the group.

1       “(c) DOMICILIARY STATE.—For purposes of this sec-  
 2       tion, a qualified small employer purchasing group oper-  
 3       ating in more than one State shall be certified by the State  
 4       in which the group is domiciled.

5       “(d) MEMBERSHIP.—

6               “(1) IN GENERAL.—A qualified small employer  
 7       purchasing group shall accept all small employers  
 8       and certain uninsured individuals residing within the  
 9       area served by the group as members if such em-  
 10      ployers or individuals request such membership.

11              “(2) VOTING.—Members of a qualified small  
 12      employer purchasing group shall have voting rights  
 13      consistent with the rules established by the State.

14       “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-  
 15      CHASING GROUPS.—Each qualified small employer pur-  
 16      chasing group shall—

17              “(1) enter into agreements with insurers offer-  
 18      ing qualified group health plans;

19              “(2) enter into agreements with small employ-  
 20      ers under section 721F;

21              “(3) enroll only eligible employees, eligible indi-  
 22      viduals, and certain uninsured individuals in quali-  
 23      fied group health plans, in accordance with section  
 24      721G;

25              “(4) provide enrollee information to the State;

1 “(5) meet the marketing requirements under  
2 section 721I; and

3 “(6) carry out other functions provided for  
4 under this subpart.

5 “(f) LIMITATION ON ACTIVITIES.—A qualified small  
6 employer purchasing group shall not—

7 “(1) perform any activity involving approval or  
8 enforcement of payment rates for providers;

9 “(2) perform any activity (other than the re-  
10 porting of noncompliance) relating to compliance of  
11 qualified group health plans with the requirements  
12 of this subpart;

13 “(3) assume financial risk in relation to any  
14 such health plan; or

15 “(4) perform other activities identified by the  
16 State as being inconsistent with the performance of  
17 its duties under this subpart.

18 “(g) RULES OF CONSTRUCTION.—

19 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-  
20 ing in this section shall be construed as requiring—

21 “(A) that a State organize, operate or oth-  
22 erwise establish a qualified small employer pur-  
23 chasing group, or otherwise require the estab-  
24 lishment of purchasing groups; and

1           “(B) that there be only one qualified small  
2           employer purchasing group established with re-  
3           spect to a community rating area.

4           “(2) SINGLE ORGANIZATION SERVING MUL-  
5           TIPLE AREAS AND STATES.—Nothing in this section  
6           shall be construed as preventing a single entity from  
7           being a qualified small employer purchasing group in  
8           more than one community rating area or in more  
9           than one State.

10          “(3) VOLUNTARY PARTICIPATION.—Nothing in  
11          this section shall be construed as requiring any indi-  
12          vidual or small employer to purchase a qualified  
13          group health plan exclusively through a qualified  
14          small employer purchasing group.

15       **“SEC. 721F. AGREEMENTS WITH SMALL EMPLOYERS.**

16          “(a) IN GENERAL.—A qualified small employer pur-  
17          chasing group shall offer to enter into an agreement under  
18          this section with each small employer that employs eligible  
19          employees in the area served by the group.

20          “(b) PAYROLL DEDUCTION.—

21               “(1) IN GENERAL.—Under an agreement under  
22          this section between a small employer and a quali-  
23          fied small employer purchasing group, the small em-  
24          ployer shall deduct premiums from an eligible em-  
25          ployee’s wages.

1           “(2) **ADDITIONAL PREMIUMS.**—If the amount  
 2           withheld under paragraph (1) is not sufficient to  
 3           cover the entire cost of the premiums, the eligible  
 4           employee shall be responsible for paying directly to  
 5           the qualified small employer purchasing group the  
 6           difference between the amount of such premiums  
 7           and the amount withheld.

8   **“SEC. 721G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**  
 9                           **INDIVIDUALS, AND CERTAIN UNINSURED IN-**  
 10                          **DIVIDUALS IN QUALIFIED GROUP HEALTH**  
 11                          **PLANS.**

12       “(a) **IN GENERAL.**—Each qualified small employer  
 13       purchasing group shall offer—

14               “(1) eligible employees,

15               “(2) eligible individuals, and

16               “(3) certain uninsured individuals,

17       the opportunity to enroll in any qualified group health  
 18       plan which has an agreement with the qualified small em-  
 19       ployer purchasing group for the community rating area  
 20       in which such employees and individuals reside.

21       “(b) **UNINSURED INDIVIDUALS.**—For purposes of  
 22       this section, an individual is described in subsection (a)(3)  
 23       if such individual is an uninsured individual who is not  
 24       an eligible employee of a small employer that is a member

1 of a qualified small employer purchasing group or a de-  
 2 pendent of such individual.

3 **“SEC. 721H. RECEIPT OF PREMIUMS.**

4 “(a) ENROLLMENT CHARGE.—The amount charged  
 5 by a qualified small employer purchasing group for cov-  
 6 erage under a qualified group health plan shall be equal  
 7 to the sum of—

8 “(1) the premium rate offered by such health  
 9 plan;

10 “(2) the administrative charge for such health  
 11 plan; and

12 “(3) the purchasing group administrative  
 13 charge for enrollment of eligible employees, eligible  
 14 individuals and certain uninsured individuals  
 15 through the group.

16 “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-  
 17 ISTRATIVE CHARGES.—Each qualified small employer  
 18 purchasing group shall, prior to the time of enrollment,  
 19 disclose to enrollees and other interested parties the pre-  
 20 mium rate for a qualified group health plan, the adminis-  
 21 trative charge for such plan, and the administrative charge  
 22 of the group, separately.

23 **“SEC. 721I. MARKETING ACTIVITIES.**

24 “Each qualified small employer purchasing group  
 25 shall market qualified group health plans to members



1 through the entire community rating area served by the  
 2 purchasing group.

3 **“SEC. 721J. GRANTS TO STATES AND QUALIFIED SMALL EM-**  
 4 **PLOYER PURCHASING GROUPS.**

5 “(a) IN GENERAL.—The Secretary shall award  
 6 grants to States and small employer purchasing groups  
 7 to assist such States and groups in planning, developing,  
 8 and operating qualified small employer purchasing groups.

9 “(b) APPLICATION REQUIREMENTS.—To be eligible  
 10 to receive a grant under this section, a State or small em-  
 11 ployer purchasing group shall prepare and submit to the  
 12 Secretary an application in such form, at such time, and  
 13 containing such information, certifications, and assur-  
 14 ances as the Secretary shall reasonably require.

15 “(c) USE OF FUNDS.—Amounts awarded under this  
 16 section may be used to finance the costs associated with  
 17 planning, developing, and operating a qualified small em-  
 18 ployer purchasing group. Such costs may include the costs  
 19 associated with—

20 “(1) engaging in education and outreach efforts  
 21 to inform small employers, insurers, and the public  
 22 about the small employer purchasing group;

23 “(2) soliciting bids and negotiating with insur-  
 24 ers to make available group health plans;

1           “(3) preparing the documentation required to  
2       receive certification by the Secretary as a qualified  
3       small employer purchasing group; and

4           “(4) such other activities determined appro-  
5       priate by the Secretary.

6       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
7       are authorized to be appropriated for awarding grants  
8       under this section such sums as may be necessary.

9       **“SEC. 721K. QUALIFIED SMALL EMPLOYER PURCHASING**  
10           **GROUPS ESTABLISHED BY A STATE.**

11       “A State may establish a system in all or part of the  
12       State under which qualified small employer purchasing  
13       groups are the sole mechanism through which health care  
14       coverage for the eligible employees of small employers shall  
15       be purchased or provided.

16       **“SEC. 721L. EFFECTIVE DATES.**

17       “(a) IN GENERAL.—Except as provided in this chap-  
18       ter, the provisions of this chapter are effective on the date  
19       of the enactment of this subpart.

20       “(b) EXCEPTION.—The provisions of section 721C(b)  
21       shall apply to contracts which are issued, or renewed, after  
22       the date which is 18 months after the date of the enact-  
23       ment of this subpart.

1 **“CHAPTER 2—REQUIRED COVERAGE OPTIONS**  
2 **FOR ELIGIBLE EMPLOYEES AND DEPEND-**  
3 **ENTS OF SMALL EMPLOYERS**

4 **“SEC. 722. REQUIRING SMALL EMPLOYERS TO OFFER COV-**  
5 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

6 “(a) REQUIREMENT TO OFFER.—Each small em-  
7 ployer shall make available with respect to each eligible  
8 employee a group health plan under which—

9 “(1) coverage of each eligible individual with re-  
10 spect to such an eligible employee may be elected on  
11 an annual basis for each plan year;

12 “(2) coverage is provided for at least the stand-  
13 ard coverage specified in section 721A(b); and

14 “(3) each eligible employee electing such cov-  
15 erage may elect to have any premiums owed by the  
16 employee collected through payroll deduction.

17 “(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An  
18 employer is not required under subsection (a) to make any  
19 contribution to the cost of coverage under a group health  
20 plan described in such subsection.

21 “(c) SPECIAL RULES.—

22 “(1) EXCLUSION OF NEW EMPLOYERS AND  
23 CERTAIN VERY SMALL EMPLOYERS.—Subsection (a)  
24 shall not apply to any small employer for any plan  
25 year if, as of the beginning of such plan year—

1           “(A) such employer (including any prede-  
2           cessor thereof) has been an employer for less  
3           than 2 years;

4           “(B) such employer has no more than 2 el-  
5           igible employees; or

6           “(C) no more than 2 eligible employees are  
7           not covered under any group health plan.

8           “(2) EXCLUSION OF FAMILY MEMBERS.—Under  
9           such procedures as the Secretary may prescribe, any  
10          relative of a small employer may be, at the election  
11          of the employer, excluded from consideration as an  
12          eligible employee for purposes of applying the re-  
13          quirements of subsection (a). In the case of a small  
14          employer that is not an individual, an employee who  
15          is a relative of a key employee (as defined in section  
16          416(i)(1) of the Internal Revenue Code of 1986) of  
17          the employer may, at the election of the key em-  
18          ployee, be considered a relative excludable under this  
19          paragraph.

20          “(3) OPTIONAL APPLICATION OF WAITING PE-  
21          RIOD.—A group health plan and a health insurance  
22          issuer offering group health insurance coverage shall  
23          not be treated as failing to meet the requirements of  
24          subsection (a) solely because a period of service by  
25          an eligible employee of not more than 60 days is re-

1       quired under the plan for coverage under the plan  
 2       of eligible individuals with respect to such employee.

3       “(d) CONSTRUCTION.—Nothing in this section shall  
 4 be construed as limiting the group health plans, or types  
 5 of coverage under such a plan, that an employer may offer  
 6 to an employee.

7       **“SEC. 722A. COMPLIANCE WITH APPLICABLE REQUIRE-**  
 8                               **MENTS THROUGH MULTIPLE EMPLOYER**  
 9                               **HEALTH ARRANGEMENTS.**

10       “(a) IN GENERAL.—In any case in which an eligible  
 11 employee is, for any plan year, a participant in a group  
 12 health plan which is a multiemployer plan, the require-  
 13 ments of section 722(a) shall be deemed to be met with  
 14 respect to such employee for such plan year if the em-  
 15 ployer requirements of subsection (b) are met with respect  
 16 to the eligible employee, irrespective of whether, or to what  
 17 extent, the employer makes employer contributions on be-  
 18 half of the eligible employee.

19       “(b) EMPLOYER REQUIREMENTS.—The employer re-  
 20 quirements of this subsection are met under a group  
 21 health plan with respect to an eligible employee if—

22               “(1) the employee is eligible under the plan to  
 23 elect coverage on an annual basis and is provided a  
 24 reasonable opportunity to make the election in such

1 form and manner and at such times as are provided  
 2 by the plan;

3 “(2) coverage is provided for at least the stand-  
 4 ard coverage specified in section 721A(b);

5 “(3) the employer facilitates collection of any  
 6 employee contributions under the plan and permits  
 7 the employee to elect to have employee contributions  
 8 under the plan collected through payroll deduction;  
 9 and

10 “(4) in the case of a plan to which part 1 does  
 11 not otherwise apply, the employer provides to the  
 12 employee a summary plan description described in  
 13 section 102(a)(1) in the form and manner and at  
 14 such times as are required under such part 1 with  
 15 respect to employee welfare benefit plans.

16 **“CHAPTER 3—REQUIRED COVERAGE OPTIONS**  
 17 **FOR INDIVIDUALS INSURED THROUGH ASSO-**  
 18 **CIATION PLANS**

19 **“Subchapter A—Qualified Association Plans**

20 **“SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION**  
 21 **PLANS.**

22 “(a) GENERAL RULE.—For purposes of this chapter,  
 23 in the case of a qualified association plan—

24 “(1) except as otherwise provided in this sub-  
 25 chapter, the plan shall meet all applicable require-

1       ments of chapter 1 and chapter 2 for group health  
2       plans offered to and by small employers;

3           “(2) if such plan is certified as meeting such  
4       requirements and the requirements of this sub-  
5       chapter, such plan shall be treated as a plan estab-  
6       lished and maintained by a small employer, and indi-  
7       viduals enrolled in such plan shall be treated as eli-  
8       gible employees; and

9           “(3) any individual who is a member of the as-  
10      sociation not enrolling in the plan shall not be treat-  
11      ed as an eligible employee solely by reason of mem-  
12      bership in such association.

13      “(b) ELECTION TO BE TREATED AS PURCHASING  
14      COOPERATIVE.—Subsection (a) shall not apply to a quali-  
15      fied association plan if—

16           “(1) the health insurance issuer makes an irrev-  
17      ocable election to be treated as a qualified small em-  
18      ployer purchasing group for purposes of section  
19      721D; and

20           “(2) such sponsor meets all requirements of  
21      this subpart applicable to a purchasing cooperative.

22      **“SEC. 723A. QUALIFIED ASSOCIATION PLAN DEFINED.**

23           “(a) GENERAL RULE.—For purposes of this chapter,  
24      a plan is a qualified association plan if the plan is a mul-

1 tiple employer welfare arrangement or similar  
2 arrangement—

3 “(1) which is maintained by a qualified associa-  
4 tion;

5 “(2) which has at least 500 participants in the  
6 United States;

7 “(3) under which the benefits provided consist  
8 solely of medical care (as defined in section 213(d)  
9 of the Internal Revenue Code of 1986);

10 “(4) which may not condition participation in  
11 the plan, or terminate coverage under the plan, on  
12 the basis of the health status or health claims expe-  
13 rience of any employee or member or dependent of  
14 either;

15 “(5) which provides for bonding, in accordance  
16 with regulations providing rules similar to the rules  
17 under section 412, of all persons operating or ad-  
18 ministering the plan or involved in the financial af-  
19 fairs of the plan; and

20 “(6) which notifies each participant or provider  
21 that it is certified as meeting the requirements of  
22 this chapter applicable to it.

23 “(b) SELF-INSURED PLANS.—In the case of a plan  
24 which is not fully insured (within the meaning of section



1 514(b)(6)(D)), the plan shall be treated as a qualified as-  
 2 sociation plan only if—

3 “(1) the plan meets minimum financial solvency  
 4 and cash reserve requirements for claims which are  
 5 established by the Secretary and which shall be in  
 6 lieu of any other such requirements under this chap-  
 7 ter;

8 “(2) the plan provides an annual funding report  
 9 (certified by an independent actuary) and annual fi-  
 10 nancial statements to the Secretary and other inter-  
 11 ested parties; and

12 “(3) the plan appoints a plan sponsor who is  
 13 responsible for operating the plan and ensuring com-  
 14 pliance with applicable Federal and State laws.

15 “(c) CERTIFICATION.—

16 “(1) IN GENERAL.—A plan shall not be treated  
 17 as a qualified association plan for any period unless  
 18 there is in effect a certification by the Secretary that  
 19 the plan meets the requirements of this subchapter.  
 20 For purposes of this chapter, the Secretary shall be  
 21 the appropriate certifying authority with respect to  
 22 the plan.

23 “(2) FEE.—The Secretary shall require a  
 24 \$5,000 fee for the original certification under para-  
 25 graph (1) and may charge a reasonable annual fee

1 to cover the costs of processing and reviewing the  
2 annual statements of the plan.

3 “(3) EXPEDITED PROCEDURES.—The Secretary  
4 may by regulation provide for expedited registration,  
5 certification, and comment procedures.

6 “(4) AGREEMENTS.—The Secretary of Labor  
7 may enter into agreements with the States to carry  
8 out the Secretary’s responsibilities under this sub-  
9 chapter.

10 “(d) AVAILABILITY.—Notwithstanding any other  
11 provision of this chapter, a qualified association plan may  
12 limit coverage to individuals who are members of the  
13 qualified association establishing or maintaining the plan,  
14 an employee of such member, or a dependent of either.

15 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the  
16 case of a plan in existence on January 1, 2001—

17 “(1) the requirements of subsection (a) (other  
18 than paragraphs (4), (5), and (6) thereof) shall not  
19 apply;

20 “(2) no original certification shall be required  
21 under this subchapter; and

22 “(3) no annual report or funding statement  
23 shall be required before January 1, 2003, but the  
24 plan shall file with the Secretary a description of the  
25 plan and the name of the health insurance issuer.

1 **“SEC. 723B. DEFINITIONS AND SPECIAL RULES.**

2 “(a) QUALIFIED ASSOCIATION.—For purposes of this  
3 subchapter, the term ‘qualified association’ means any or-  
4 ganization which—

5 “(1) is organized and maintained in good faith  
6 by a trade association, an industry association, a  
7 professional association, a chamber of commerce, a  
8 religious organization, a public entity association, or  
9 other business association serving a common or simi-  
10 lar industry;

11 “(2) is organized and maintained for substan-  
12 tial purposes other than to provide a health plan;

13 “(3) has a constitution, bylaws, or other similar  
14 governing document which states its purpose; and

15 “(4) receives a substantial portion of its finan-  
16 cial support from its active, affiliated, or federation  
17 members.

18 “(b) COORDINATION.—The term ‘qualified associa-  
19 tion plan’ shall not include a plan to which subchapter  
20 B applies.

1           **“Subchapter B—Special Rule for Church,**  
 2           **Multiemployer, and Cooperative Plans**

3   **“SEC. 723F. SPECIAL RULE FOR CHURCH, MULTIEM-**  
 4           **PLOYER, AND COOPERATIVE PLANS.**

5           “(a) GENERAL RULE.—For purposes of this chapter,  
 6 in the case of a group health plan to which this section  
 7 applies—

8           “(1) except as otherwise provided in this sub-  
 9 chapter, the plan shall be required to meet all appli-  
 10 cable requirements of chapter 1 and chapter 2 for  
 11 group health plans offered to and by small employ-  
 12 ers;

13           “(2) if such plan is certified as meeting such  
 14 requirements, such plan shall be treated as a plan  
 15 established and maintained by a small employer and  
 16 individuals enrolled in such plan shall be treated as  
 17 eligible employees; and

18           “(3) any individual eligible to enroll in the plan  
 19 who does not enroll in the plan shall not be treated  
 20 as an eligible employee solely by reason of being eli-  
 21 gible to enroll in the plan.

22           “(b) MODIFIED STANDARDS.—

23           “(1) CERTIFYING AUTHORITY.—For purposes  
 24 of this chapter, the Secretary shall be the appro-  
 25 priate certifying authority with respect to a plan to  
 26 which this section applies.

1           “(2) AVAILABILITY.—Rules similar to the rules  
2 of subsection (e) of section 723A shall apply to a  
3 plan to which this section applies.

4           “(3) ACCESS.—An employer which, pursuant to  
5 a collective bargaining agreement, offers an em-  
6 ployee the opportunity to enroll in a plan described  
7 in subsection (c)(2) shall not be required to make  
8 any other plan available to the employee.

9           “(4) TREATMENT UNDER STATE LAWS.—A  
10 church plan described in subsection (c)(1) which is  
11 certified as meeting the requirements of this section  
12 shall not be deemed to be a multiple employer wel-  
13 fare arrangement or an insurance company or other  
14 insurer, or to be engaged in the business of insur-  
15 ance, for purposes of any State law purporting to  
16 regulate insurance companies or insurance contracts.

17           “(c) PLANS TO WHICH SECTION APPLIES.—This sec-  
18 tion shall apply to a health plan which—

19           “(1) is a church plan (as defined in section  
20 414(e) of the Internal Revenue Code of 1986) which  
21 has at least 100 participants in the United States;

22           “(2) is a multiemployer plan which is main-  
23 tained by a health plan sponsor described in section  
24 3(16)(B)(iii) and which has at least 500 participants  
25 in the United States; or

1           “(3) is a plan which is maintained by a rural  
2       electric cooperative or a rural telephone cooperative  
3       association and which has at least 500 participants  
4       in the United States.”.

5       (b) CONFORMING AMENDMENTS.—Section 731(d) of  
6       the Employee Retirement Income Security Act of 1974  
7       (29 U.S.C. 1186(d)) is amended by adding at the end the  
8       following:

9           “(3) ELIGIBLE EMPLOYEE.—The term ‘eligible  
10      employee’ means, with respect to an employer, an  
11      employee who normally performs on a monthly basis  
12      at least 30 hours of service per week for that em-  
13      ployer.

14          “(4) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
15      individual’ means, with respect to an eligible em-  
16      ployee, such employee, and any dependent of such  
17      employee.

18          “(5) NAIC.—The term ‘NAIC’ means the Na-  
19      tional Association of Insurance Commissioners.

20          “(6) QUALIFIED GROUP HEALTH PLAN.—The  
21      term ‘qualified group health plan’ shall have the  
22      meaning given the term in section 721.”.

1 **SEC. 402. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

2 **ACT RELATING TO THE GROUP MARKET.**

3 (a) IN GENERAL.—Subpart 2 of part A of title  
4 XXVII of the Public Health Service Act (42 U.S.C.  
5 300gg-4 et seq.) is amended—

6 (1) by inserting after the subpart heading the  
7 following:

8 **“CHAPTER 1—MISCELLANEOUS REQUIREMENTS”;**

9 and

10 (2) by adding at the end the following:

11 **“CHAPTER 2—GENERAL INSURANCE COVERAGE**

12 **REFORMS**

13 **“Subchapter A—Increased Availability and**

14 **Continuity of Health Coverage**

15 **“SEC. 2707. DEFINITION.**

16 “As used in this chapter, the term ‘qualified group  
17 health plan’ means a group health plan, and a health in-  
18 surance issuer offering group health insurance coverage,  
19 that is designed to provide standard coverage (consistent  
20 with section 2707A(b)).

21 **“SEC. 2707A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**  
22 **MITTED.**

23 **“(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—**

24 **“(1) INITIAL DETERMINATION.—**The NAIC is  
25 requested to submit to the Secretary, within 6  
26 months after the date of the enactment of this chap-

1       ter, a set of rules which the NAIC determines is suf-  
 2       ficient for determining, in the case of any group  
 3       health plan, or a health insurance issuer offering  
 4       group health insurance coverage, and for purposes of  
 5       this section, the actuarial value of the coverage of-  
 6       fered by the plan or coverage.

7           “(2) CERTIFICATION.—If the Secretary deter-  
 8       mines that the NAIC has submitted a set of rules  
 9       that comply with the requirements of paragraph (1),  
 10      the Secretary shall certify such set of rules for use  
 11      under this chapter. If the Secretary determines that  
 12      such a set of rules has not been submitted or does  
 13      not comply with such requirements, the Secretary  
 14      shall promptly establish a set of rules that meets  
 15      such requirements.

16      “(b) STANDARD COVERAGE.—

17           “(1) IN GENERAL.—A a group health plan, and  
 18      a health insurance issuer offering group health in-  
 19      surance coverage, shall be considered to provide  
 20      standard coverage consistent with this subsection if  
 21      the benefits are determined, in accordance with the  
 22      set of actuarial equivalence rules certified under sub-  
 23      section (a), to have a value that is within 5 percent-  
 24      age points of the target actuarial value for standard  
 25      coverage established under paragraph (2).



1           “(2) INITIAL DETERMINATION OF TARGET AC-  
2           TUARIAL VALUE FOR STANDARD COVERAGE.—

3           “(A) INITIAL DETERMINATION.—

4           “(i) IN GENERAL.—The NAIC is re-  
5           quested to submit to the Secretary, within  
6           6 months after the date of the enactment  
7           of this chapter, a target actuarial value for  
8           standard coverage equal to the average ac-  
9           tuarial value of the coverage described in  
10          clause (ii). No specific procedure or treat-  
11          ment, or classes thereof, is required to be  
12          considered in such determination by this  
13          chapter or through regulations. The deter-  
14          mination of such value shall be based on a  
15          representative distribution of the popu-  
16          lation of eligible employees offered such  
17          coverage and a single set of standardized  
18          utilization and cost factors.

19          “(ii) COVERAGE DESCRIBED.—The  
20          coverage described in this clause is cov-  
21          erage for medically necessary and appro-  
22          priate services consisting of medical and  
23          surgical services, medical equipment, pre-  
24          ventive services, and emergency transpor-  
25          tation in frontier areas. No specific proce-

1           dure or treatment, or classes thereof, is re-  
 2           quired to be covered in such a plan, by this  
 3           chapter or through regulations.

4           “(B) CERTIFICATION.—If the Secretary  
 5           determines that the NAIC has submitted a tar-  
 6           get actuarial value for standard coverage that  
 7           complies with the requirements of subparagraph  
 8           (A), the Secretary shall certify such value for  
 9           use under this chapter. If the Secretary deter-  
 10          mines that a target actuarial value has not been  
 11          submitted or does not comply with the require-  
 12          ments of subparagraph (A), the Secretary shall  
 13          promptly determine a target actuarial value  
 14          that meets such requirements.

15          “(c) SUBSEQUENT REVISIONS.—

16          “(1) NAIC.—The NAIC may submit from time  
 17          to time to the Secretary revisions of the set of rules  
 18          of actuarial equivalence and target actuarial values  
 19          previously established or determined under this sec-  
 20          tion if the NAIC determines that revisions are nec-  
 21          essary to take into account changes in the relevant  
 22          types of health benefits provisions or in demographic  
 23          conditions which form the basis for the set of rules  
 24          of actuarial equivalence or the target actuarial val-  
 25          ues. The provisions of subsection (a)(2) shall apply

1 to such a revision in the same manner as they apply  
 2 to the initial determination of the set of rules.

3 “(2) SECRETARY.—The Secretary may by regu-  
 4 lation revise the set of rules of actuarial equivalence  
 5 and target actuarial values from time to time if the  
 6 Secretary determines such revisions are necessary to  
 7 take into account changes described in paragraph  
 8 (1).

9 **“SEC. 2707B. ESTABLISHMENT OF PLAN STANDARDS.**

10 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

11 “(1) ROLE OF NAIC.—The NAIC is requested  
 12 to submit to the Secretary, within 9 months after  
 13 the date of the enactment of this chapter, model reg-  
 14 ulations that specify standards for making qualified  
 15 group health plans available to small employers. If  
 16 the NAIC develops recommended regulations speci-  
 17 fying such standards within such period, the Sec-  
 18 retary shall review the standards. Such review shall  
 19 be completed within 60 days after the date the regu-  
 20 lations are developed. Such standards shall serve as  
 21 the standards under this section, with such amend-  
 22 ments as the Secretary deems necessary. Such  
 23 standards shall be nonbinding (except as provided in  
 24 chapter 4).

1           “(2) CONTINGENCY.—If the NAIC does not de-  
2       velop such model regulations within the period de-  
3       scribed in paragraph (1), the Secretary shall specify,  
4       within 15 months after the date of the enactment of  
5       this chapter, model regulations that specify stand-  
6       ards for insurers with regard to making qualified  
7       group health plans available to small employers.  
8       Such standards shall be nonbinding (except as pro-  
9       vided in chapter 4).

10           “(3) EFFECTIVE DATE.—The standards speci-  
11       fied in the model regulations shall apply to group  
12       health plans and health insurance issuers offering  
13       group health insurance coverage in a State on or  
14       after the respective date the standards are imple-  
15       mented in the State.

16           “(b) NO PREEMPTION OF STATE LAW.—A State may  
17       implement standards for group health plans available, and  
18       health insurance issuers offering group health insurance  
19       coverage offered, to small employers that are more strin-  
20       gent than the standards under this section, except that  
21       a State may not implement standards that prevent the of-  
22       fering of at least one group health plan that provides  
23       standard coverage (as described in section 2707A(b)).

1 **“SEC. 2707C. RATING LIMITATIONS FOR COMMUNITY-**  
2 **RATED MARKET.**

3 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-  
4 MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-  
5 DIVIDUALS.—

6 “(1) IN GENERAL.—Each group health plan of-  
7 fered, and each health insurance issuer offering  
8 group health insurance coverage, to a small em-  
9 ployer shall establish within each community rating  
10 area in which the plan is to be offered, a standard  
11 premium for enrollment of eligible employees and eli-  
12 gible individuals for the standard coverage (as de-  
13 fined under section 2707A(b)).

14 “(2) ESTABLISHMENT OF COMMUNITY RATING  
15 AREA.—

16 “(A) IN GENERAL.—Not later than Janu-  
17 ary 1, 2002, each State shall, in accordance  
18 with subparagraph (B), provide for the division  
19 of the State into 1 or more community rating  
20 areas. The State may revise the boundaries of  
21 such areas from time to time consistent with  
22 this paragraph.

23 “(B) GEOGRAPHIC AREA VARIATIONS.—  
24 For purposes of subparagraph (A), a State—

1 “(i) may not identify an area that di-  
 2 vides a 3-digit zip code, a county, or all  
 3 portions of a metropolitan statistical area;

4 “(ii) shall not permit premium rates  
 5 for coverage offered in a portion of an  
 6 interstate metropolitan statistical area to  
 7 vary based on the State in which the cov-  
 8 erage is offered; and

9 “(iii) may, upon agreement with one  
 10 or more adjacent States, identify multi-  
 11 State geographic areas consistent with  
 12 clauses (i) and (ii).

13 “(3) ELIGIBLE INDIVIDUALS.—For purposes of  
 14 this section, the term ‘eligible individuals’ includes  
 15 certain uninsured individuals (as described in section  
 16 2707G).

17 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
 18 ING AREAS.—

19 “(1) IN GENERAL.—Subject to paragraphs (2)  
 20 and (3), the standard premium for each group  
 21 health plan to which this section applies shall be the  
 22 same, but shall not include the costs of premium  
 23 processing and enrollment that may vary depending  
 24 on whether the method of enrollment is through a

1 qualified small employer purchasing group, through  
2 a small employer, or through a broker.

3 “(2) APPLICATION TO ENROLLEES.—

4 “(A) IN GENERAL.—The premium charged  
5 for coverage in a group health plan which cov-  
6 ers eligible employees and eligible individuals  
7 shall be the product of—

8 “(i) the standard premium (estab-  
9 lished under paragraph (1));

10 “(ii) in the case of enrollment other  
11 than individual enrollment, the family ad-  
12 justment factor specified under subpara-  
13 graph (B); and

14 “(iii) the age adjustment factor (spec-  
15 ified under subparagraph (C)).

16 “(B) FAMILY ADJUSTMENT FACTOR.—

17 “(i) IN GENERAL.—The standards es-  
18 tablished under section 2707B shall specify  
19 family adjustment factors that reflect the  
20 relative actuarial costs of benefit packages  
21 based on family classes of enrollment (as  
22 compared with such costs for individual en-  
23 rollment).

“(ii) CLASSES OF ENROLLMENT.—For purposes of this chapter, there are 4 classes of enrollment:

“(I) Coverage only of an individual (referred to in this chapter as the ‘individual’ enrollment or class of enrollment).

“(II) Coverage of a married couple without children (referred to in this chapter as the ‘couple-only’ enrollment or class of enrollment).

“(III) Coverage of an individual and one or more children (referred to in this chapter as the ‘single parent’ enrollment or class of enrollment).

“(IV) Coverage of a married couple and one or more children (referred to in this chapter as the ‘dual parent’ enrollment or class of enrollment).

“(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this chapter:

“(I) FAMILY.—The terms ‘family enrollment’ and ‘family class of enrollment’ refer to enrollment in a class of



1 enrollment described in any subclause  
 2 of clause (ii) (other than subclause  
 3 (I)).

4 “(II) COUPLE.—The term ‘couple  
 5 class of enrollment’ refers to enroll-  
 6 ment in a class of enrollment de-  
 7 scribed in subclause (II) or (IV) of  
 8 clause (ii).

9 “(iv) SPOUSE; MARRIED; COUPLE.—

10 “(I) IN GENERAL.—In this chap-  
 11 ter, the terms ‘spouse’ and ‘married’  
 12 mean, with respect to an individual,  
 13 another individual who is the spouse  
 14 of, or is married to, the individual, as  
 15 determined under applicable State  
 16 law.

17 “(II) COUPLE.—The term ‘cou-  
 18 ple’ means an individual and the indi-  
 19 vidual’s spouse.

20 “(C) AGE ADJUSTMENT FACTOR.—The  
 21 Secretary, in consultation with the NAIC, shall  
 22 specify uniform age categories and maximum  
 23 rating increments for age adjustment factors  
 24 that reflect the relative actuarial costs of ben-  
 25 efit packages among enrollees. For individuals

1           who have attained age 18 but not age 65, the  
2           highest age adjustment factor may not exceed 3  
3           times the lowest age adjustment factor.

4           “(3) ADMINISTRATIVE CHARGES.—

5                 “(A) IN GENERAL.—In accordance with  
6           the standards established under section 2707B,  
7           a group health plan which covers eligible em-  
8           ployees and eligible individuals may add a sepa-  
9           rately-stated administrative charge which is  
10          based on identifiable differences in legitimate  
11          administrative costs and which is applied uni-  
12          formly for individuals enrolling through the  
13          same method of enrollment. Nothing in this  
14          subparagraph may be construed as preventing a  
15          qualified small employer purchasing group from  
16          negotiating a unique administrative charge with  
17          an insurer for a group health plan.

18                 “(B) ENROLLMENT THROUGH A QUALI-  
19          FIED SMALL EMPLOYER PURCHASING GROUP.—  
20          In the case of an administrative charge under  
21          subparagraph (A) for enrollment through a  
22          qualified small employer purchasing group, such  
23          charge may not exceed the lowest charge of  
24          such plan for enrollment other than through a

1           qualified small employer purchasing group in  
2           such area.

3           “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-  
4 NITY RATE.—Notwithstanding any other provision of this  
5 section, a group health plan and a health insurance issuer  
6 offering health insurance coverage that negotiates a pre-  
7 mium rate (exclusive of any administrative charge de-  
8 scribed in subsection (b)(3)) with a qualified small em-  
9 ployer purchasing group in a community rating area shall  
10 charge the same premium rate to all eligible employees  
11 and eligible individuals.

12   **“SEC. 2707D. RATING PRACTICES AND PAYMENT OF PRE-**  
13                           **MIUMS.**

14           “(a) FULL DISCLOSURE OF RATING PRACTICES.—

15                   “(1) IN GENERAL.—A group health plan and a  
16           health insurance issuer offering health insurance  
17           coverage shall fully disclose rating practices for the  
18           plan to the appropriate certifying authority.

19                   “(2) NOTICE ON EXPIRATION.—A group health  
20           plan and a health insurance issuer offering health  
21           insurance coverage shall provide for notice of the  
22           terms for renewal of a plan at the time of the offer-  
23           ing of the plan and at least 90 days before the date  
24           of expiration of the plan.

1           “(3) ACTUARIAL CERTIFICATION.—Each group  
 2       health plan and health insurance issuer offering  
 3       health insurance coverage shall file annually with the  
 4       appropriate certifying authority a written statement  
 5       by a member of the American Academy of Actuaries  
 6       (or other individual acceptable to such authority)  
 7       who is not an employee of the group health plan or  
 8       issuer certifying that, based upon an examination by  
 9       the individual which includes a review of the appro-  
 10      priate records and of the actuarial assumptions of  
 11      such plan or insurer and methods used by the plan  
 12      or insurer in establishing premium rates and admin-  
 13      istrative charges for group health plans—

14               “(A) such plan or insurer is in compliance  
 15              with the applicable provisions of this chapter;  
 16              and

17               “(B) the rating methods are actuarially  
 18              sound.

19       Each plan and insurer shall retain a copy of such  
 20       statement at its principal place of business for exam-  
 21       ination by any individual.

22       “(b) PAYMENT OF PREMIUMS.—

23               “(1) IN GENERAL.—With respect to a new en-  
 24       rollee in a group health plan, the plan may require  
 25       advanced payment of an amount equal to the month-

1 ly applicable premium for the plan at the time such  
 2 individual is enrolled.

3 “(2) NOTIFICATION OF FAILURE TO RECEIVE  
 4 PREMIUM.—If a group health plan or a health insur-  
 5 ance issuer offering health insurance coverage fails  
 6 to receive payment on a premium due with respect  
 7 to an eligible employee or eligible individual covered  
 8 under the plan involved, the plan or issuer shall pro-  
 9 vide notice of such failure to the employee or indi-  
 10 vidual within the 20-day period after the date on  
 11 which such premium payment was due. A plan or  
 12 issuer may not terminate the enrollment of an eligi-  
 13 ble employee or eligible individual unless such em-  
 14 ployee or individual has been notified of any overdue  
 15 premiums and has been provided a reasonable op-  
 16 portunity to respond to such notice.

17 **“SEC. 2707E. QUALIFIED SMALL EMPLOYER PURCHASING**  
 18 **GROUPS.**

19 “(a) QUALIFIED SMALL EMPLOYER PURCHASING  
 20 GROUPS DESCRIBED.—

21 “(1) IN GENERAL.—A qualified small employer  
 22 purchasing group is an entity that—

23 “(A) is a nonprofit entity certified under  
 24 State law;

1           “(B) has a membership consisting solely of  
2           small employers;

3           “(C) is administered solely under the au-  
4           thority and control of its member employers;

5           “(D) with respect to each State in which  
6           its members are located, consists of not fewer  
7           than the number of small employers established  
8           by the State as appropriate for such a group;

9           “(E) offers a program under which quali-  
10          fied group health plans are offered to eligible  
11          employees and eligible individuals through its  
12          member employers and to certain uninsured in-  
13          dividuals in accordance with section 2707D;  
14          and

15          “(F) an insurer, agent, broker, or any  
16          other individual or entity engaged in the sale of  
17          insurance—

18                 “(i) does not form or underwrite; and

19                 “(ii) does not hold or control any  
20                 right to vote with respect to.

21          “(2) STATE CERTIFICATION.—A qualified small  
22          employer purchasing group formed under this sec-  
23          tion shall submit an application to the State for cer-  
24          tification. The State shall determine whether to

1       issue a certification and otherwise ensure compliance  
2       with the requirements of this chapter.

3           “(3) SPECIAL RULE.—Notwithstanding para-  
4       graph (1)(B), an employer member of a small em-  
5       ployer purchasing group that has been certified by  
6       the State as meeting the requirements of paragraph  
7       (1) may retain its membership in the group if the  
8       number of employees of the employer increases such  
9       that the employer is no longer a small employer.

10       “(b) BOARD OF DIRECTORS.—Each qualified small  
11      employer purchasing group established under this section  
12      shall be governed by a board of directors or have active  
13      input from an advisory board consisting of individuals and  
14      businesses participating in the group.

15       “(c) DOMICILIARY STATE.—For purposes of this sec-  
16      tion, a qualified small employer purchasing group oper-  
17      ating in more than one State shall be certified by the State  
18      in which the group is domiciled.

19       “(d) MEMBERSHIP.—

20           “(1) IN GENERAL.—A qualified small employer  
21      purchasing group shall accept all small employers  
22      and certain uninsured individuals residing within the  
23      area served by the group as members if such em-  
24      ployers or individuals request such membership.

1           “(2) VOTING.—Members of a qualified small  
2           employer purchasing group shall have voting rights  
3           consistent with the rules established by the State.

4           “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-  
5 CHASING GROUPS.—Each qualified small employer pur-  
6 chasing group shall—

7           “(1) enter into agreements with insurers offer-  
8           ing qualified group health plans;

9           “(2) enter into agreements with small employ-  
10          ers under section 2707F;

11          “(3) enroll only eligible employees, eligible indi-  
12          viduals, and certain uninsured individuals in quali-  
13          fied group health plans, in accordance with section  
14          2707G;

15          “(4) provide enrollee information to the State;

16          “(5) meet the marketing requirements under  
17          section 2707I; and

18          “(6) carry out other functions provided for  
19          under this chapter.

20          “(f) LIMITATION ON ACTIVITIES.—A qualified small  
21          employer purchasing group shall not—

22          “(1) perform any activity involving approval or  
23          enforcement of payment rates for providers;

24          “(2) perform any activity (other than the re-  
25          porting of noncompliance) relating to compliance of



1 qualified group health plans with the requirements  
 2 of this chapter;

3 “(3) assume financial risk in relation to any  
 4 such health plan; or

5 “(4) perform other activities identified by the  
 6 State as being inconsistent with the performance of  
 7 its duties under this chapter.

8 “(g) RULES OF CONSTRUCTION.—

9 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-  
 10 ing in this section shall be construed as requiring—

11 “(A) that a State organize, operate or oth-  
 12 erwise establish a qualified small employer pur-  
 13 chasing group, or otherwise require the estab-  
 14 lishment of purchasing groups; and

15 “(B) that there be only one qualified small  
 16 employer purchasing group established with re-  
 17 spect to a community rating area.

18 “(2) SINGLE ORGANIZATION SERVING MUL-  
 19 TIPLE AREAS AND STATES.—Nothing in this section  
 20 shall be construed as preventing a single entity from  
 21 being a qualified small employer purchasing group in  
 22 more than one community rating area or in more  
 23 than one State.

24 “(3) VOLUNTARY PARTICIPATION.—Nothing in  
 25 this section shall be construed as requiring any indi-

1       vidual or small employer to purchase a qualified  
2       group health plan exclusively through a qualified  
3       small employer purchasing group.

4   **“SEC. 2707F. AGREEMENTS WITH SMALL EMPLOYERS.**

5       “(a) IN GENERAL.—A qualified small employer pur-  
6       chasing group shall offer to enter into an agreement under  
7       this section with each small employer that employs eligible  
8       employees in the area served by the group.

9       “(b) PAYROLL DEDUCTION.—

10       “(1) IN GENERAL.—Under an agreement under  
11       this section between a small employer and a quali-  
12       fied small employer purchasing group, the small em-  
13       ployer shall deduct premiums from an eligible em-  
14       ployee’s wages.

15       “(2) ADDITIONAL PREMIUMS.—If the amount  
16       withheld under paragraph (1) is not sufficient to  
17       cover the entire cost of the premiums, the eligible  
18       employee shall be responsible for paying directly to  
19       the qualified small employer purchasing group the  
20       difference between the amount of such premiums  
21       and the amount withheld.

1 **“SEC. 2707G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**  
 2 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**  
 3 **DIVIDUALS IN QUALIFIED GROUP HEALTH**  
 4 **PLANS.**

5 “(a) IN GENERAL.—Each qualified small employer  
 6 purchasing group shall offer—

7 “(1) eligible employees,

8 “(2) eligible individuals, and

9 “(3) certain uninsured individuals,

10 the opportunity to enroll in any qualified group health  
 11 plan which has an agreement with the qualified small em-  
 12 ployer purchasing group for the community rating area  
 13 in which such employees and individuals reside.

14 “(b) UNINSURED INDIVIDUALS.—For purposes of  
 15 this section, an individual is described in subsection (a)(3)  
 16 if such individual is an uninsured individual who is not  
 17 an eligible employee of a small employer that is a member  
 18 of a qualified small employer purchasing group or a de-  
 19 pendent of such individual.

20 **“SEC. 2707H. RECEIPT OF PREMIUMS.**

21 “(a) ENROLLMENT CHARGE.—The amount charged  
 22 by a qualified small employer purchasing group for cov-  
 23 erage under a qualified group health plan shall be equal  
 24 to the sum of—

25 “(1) the premium rate offered by such health  
 26 plan;

1           “(2) the administrative charge for such health  
2       plan; and

3           “(3) the purchasing group administrative  
4       charge for enrollment of eligible employees, eligible  
5       individuals and certain uninsured individuals  
6       through the group.

7       “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-  
8       ISTRATIVE CHARGES.—Each qualified small employer  
9       purchasing group shall, prior to the time of enrollment,  
10      disclose to enrollees and other interested parties the pre-  
11      mium rate for a qualified group health plan, the adminis-  
12      trative charge for such plan, and the administrative charge  
13      of the group, separately.

14   **“SEC. 2707I. MARKETING ACTIVITIES.**

15       “Each qualified small employer purchasing group  
16      shall market qualified group health plans to members  
17      through the entire community rating area served by the  
18      purchasing group.

19   **“SEC. 2707J. GRANTS TO STATES AND QUALIFIED SMALL**  
20                   **EMPLOYER PURCHASING GROUPS.**

21       “(a) IN GENERAL.—The Secretary shall award  
22      grants to States and small employer purchasing groups  
23      to assist such States and groups in planning, developing,  
24      and operating qualified small employer purchasing groups.

1       “(b) APPLICATION REQUIREMENTS.—To be eligible  
2 to receive a grant under this section, a State or small em-  
3 ployer purchasing group shall prepare and submit to the  
4 Secretary an application in such form, at such time, and  
5 containing such information, certifications, and assur-  
6 ances as the Secretary shall reasonably require.

7       “(c) USE OF FUNDS.—Amounts awarded under this  
8 section may be used to finance the costs associated with  
9 planning, developing, and operating a qualified small em-  
10 ployer purchasing group. Such costs may include the costs  
11 associated with—

12           “(1) engaging in education and outreach efforts  
13 to inform small employers, insurers, and the public  
14 about the small employer purchasing group;

15           “(2) soliciting bids and negotiating with insur-  
16 ers to make available group health plans;

17           “(3) preparing the documentation required to  
18 receive certification by the Secretary as a qualified  
19 small employer purchasing group; and

20           “(4) such other activities determined appro-  
21 priate by the Secretary.

22       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
23 are authorized to be appropriated for awarding grants  
24 under this section such sums as may be necessary.

1 **“SEC. 2707K. QUALIFIED SMALL EMPLOYER PURCHASING**  
 2 **GROUPS ESTABLISHED BY A STATE.**

3 “A State may establish a system in all or part of the  
 4 State under which qualified small employer purchasing  
 5 groups are the sole mechanism through which health care  
 6 coverage for the eligible employees of small employers shall  
 7 be purchased or provided.

8 **“SEC. 2707L. EFFECTIVE DATES.**

9 “(a) IN GENERAL.—Except as provided in this chap-  
 10 ter, the provisions of this chapter are effective on the date  
 11 of the enactment of this chapter.

12 “(b) EXCEPTION.—The provisions of section  
 13 2707C(b) shall apply to contracts which are issued, or re-  
 14 newed, after the date which is 18 months after the date  
 15 of the enactment of this chapter.

16 **“Subchapter B—Required Coverage Options for Eli-**  
 17 **gible Employees and Dependents of Small Em-**  
 18 **ployers**

19 **“SEC. 2708. REQUIRING SMALL EMPLOYERS TO OFFER COV-**  
 20 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

21 “(a) REQUIREMENT TO OFFER.—Each small em-  
 22 ployer shall make available with respect to each eligible  
 23 employee a group health plan under which—

24 “(1) coverage of each eligible individual with re-  
 25 spect to such an eligible employee may be elected on  
 26 an annual basis for each plan year;

1           “(2) coverage is provided for at least the stand-  
2           ard coverage specified in section 2707A(b); and

3           “(3) each eligible employee electing such cov-  
4           erage may elect to have any premiums owed by the  
5           employee collected through payroll deduction.

6           “(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An  
7           employer is not required under subsection (a) to make any  
8           contribution to the cost of coverage under a group health  
9           plan described in such subsection.

10          “(c) SPECIAL RULES.—

11           “(1) EXCLUSION OF NEW EMPLOYERS AND  
12           CERTAIN VERY SMALL EMPLOYERS.—Subsection (a)  
13           shall not apply to any small employer for any plan  
14           year if, as of the beginning of such plan year—

15           “(A) such employer (including any prede-  
16           cessor thereof) has been an employer for less  
17           than 2 years;

18           “(B) such employer has no more than 2 el-  
19           igible employees; or

20           “(C) no more than 2 eligible employees are  
21           not covered under any group health plan.

22           “(2) EXCLUSION OF FAMILY MEMBERS.—Under  
23           such procedures as the Secretary may prescribe, any  
24           relative of a small employer may be, at the election  
25           of the employer, excluded from consideration as an

1 eligible employee for purposes of applying the re-  
 2 quirements of subsection (a). In the case of a small  
 3 employer that is not an individual, an employee who  
 4 is a relative of a key employee (as defined in section  
 5 416(i)(1) of the Internal Revenue Code of 1986) of  
 6 the employer may, at the election of the key em-  
 7 ployee, be considered a relative excludable under this  
 8 paragraph.

9 “(3) OPTIONAL APPLICATION OF WAITING PE-  
 10 RIOD.—A group health plan and a health insurance  
 11 issuer offering group health insurance coverage shall  
 12 not be treated as failing to meet the requirements of  
 13 subsection (a) solely because a period of service by  
 14 an eligible employee of not more than 60 days is re-  
 15 quired under the plan for coverage under the plan  
 16 of eligible individuals with respect to such employee.

17 “(d) CONSTRUCTION.—Nothing in this section shall  
 18 be construed as limiting the group health plans, or types  
 19 of coverage under such a plan, that an employer may offer  
 20 to an employee.

21 **“SEC. 2708A. COMPLIANCE WITH APPLICABLE REQUIRE-**  
 22 **MENTS THROUGH MULTIPLE EMPLOYER**  
 23 **HEALTH ARRANGEMENTS.**

24 “(a) IN GENERAL.—In any case in which an eligible  
 25 employee is, for any plan year, a participant in a group



1 health plan which is a multiemployer plan, the require-  
 2 ments of section 2722(a) shall be deemed to be met with  
 3 respect to such employee for such plan year if the em-  
 4 ployer requirements of subsection (b) are met with respect  
 5 to the eligible employee, irrespective of whether, or to what  
 6 extent, the employer makes employer contributions on be-  
 7 half of the eligible employee.

8 “(b) EMPLOYER REQUIREMENTS.—The employer re-  
 9 quirements of this subsection are met under a group  
 10 health plan with respect to an eligible employee if—

11 “(1) the employee is eligible under the plan to  
 12 elect coverage on an annual basis and is provided a  
 13 reasonable opportunity to make the election in such  
 14 form and manner and at such times as are provided  
 15 by the plan;

16 “(2) coverage is provided for at least the stand-  
 17 ard coverage specified in section 2707A(b);

18 “(3) the employer facilitates collection of any  
 19 employee contributions under the plan and permits  
 20 the employee to elect to have employee contributions  
 21 under the plan collected through payroll deduction;  
 22 and

23 “(4) in the case of a plan to which subchapter  
 24 A does not otherwise apply, the employer provides to  
 25 the employee a summary plan description described

1 in section 102(a)(1) of the Employee Retirement In-  
 2 come Security Act of 1974 in the form and manner  
 3 and at such times as are required under such sub-  
 4 chapter A with respect to employee welfare benefit  
 5 plans.

6 **“Subchapter C—Required Coverage Options for**  
 7 **Individuals Insured Through Association Plans**

8 **“SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION**  
 9 **PLANS.**

10 “(a) GENERAL RULE.—For purposes of this chapter,  
 11 in the case of a qualified association plan—

12 “(1) except as otherwise provided in this sub-  
 13 chapter, the plan shall meet all applicable require-  
 14 ments of chapter 1 and chapter 2 for group health  
 15 plans offered to and by small employers;

16 “(2) if such plan is certified as meeting such  
 17 requirements and the requirements of this sub-  
 18 chapter, such plan shall be treated as a plan estab-  
 19 lished and maintained by a small employer, and indi-  
 20 viduals enrolled in such plan shall be treated as eli-  
 21 gible employees; and

22 “(3) any individual who is a member of the as-  
 23 sociation not enrolling in the plan shall not be treat-  
 24 ed as an eligible employee solely by reason of mem-  
 25 bership in such association.

1       “(b) ELECTION TO BE TREATED AS PURCHASING  
2 COOPERATIVE.—Subsection (a) shall not apply to a quali-  
3 fied association plan if—

4               “(1) the health insurance issuer makes an irrev-  
5 ovable election to be treated as a qualified small em-  
6 ployer purchasing group for purposes of section  
7 2707D; and

8               “(2) such sponsor meets all requirements of  
9 this chapter applicable to a purchasing cooperative.

10 **“SEC. 2709A. QUALIFIED ASSOCIATION PLAN DEFINED.**

11       “(a) GENERAL RULE.—For purposes of this chapter,  
12 a plan is a qualified association plan if the plan is a mul-  
13 tiple employer welfare arrangement or similar  
14 arrangement—

15               “(1) which is maintained by a qualified associa-  
16 tion;

17               “(2) which has at least 500 participants in the  
18 United States;

19               “(3) under which the benefits provided consist  
20 solely of medical care (as defined in section 213(d)  
21 of the Internal Revenue Code of 1986);

22               “(4) which may not condition participation in  
23 the plan, or terminate coverage under the plan, on  
24 the basis of the health status or health claims expe-

1        rience of any employee or member or dependent of  
 2        either;

3            “(5) which provides for bonding, in accordance  
 4        with regulations providing rules similar to the rules  
 5        under section 412, of all persons operating or ad-  
 6        ministering the plan or involved in the financial af-  
 7        fairs of the plan; and

8            “(6) which notifies each participant or provider  
 9        that it is certified as meeting the requirements of  
 10       this chapter applicable to it.

11        “(b) SELF-INSURED PLANS.—In the case of a plan  
 12       which is not fully insured (within the meaning of section  
 13       514(b)(6)(D)), the plan shall be treated as a qualified as-  
 14       sociation plan only if—

15            “(1) the plan meets minimum financial solvency  
 16        and cash reserve requirements for claims which are  
 17        established by the Secretary and which shall be in  
 18        lieu of any other such requirements under this chap-  
 19        ter;

20            “(2) the plan provides an annual funding report  
 21        (certified by an independent actuary) and annual fi-  
 22        nancial statements to the Secretary and other inter-  
 23        ested parties; and

1           “(3) the plan appoints a plan sponsor who is  
2           responsible for operating the plan and ensuring com-  
3           pliance with applicable Federal and State laws.

4           “(c) CERTIFICATION.—

5           “(1) IN GENERAL.—A plan shall not be treated  
6           as a qualified association plan for any period unless  
7           there is in effect a certification by the Secretary that  
8           the plan meets the requirements of this subchapter.  
9           For purposes of this chapter, the Secretary shall be  
10          the appropriate certifying authority with respect to  
11          the plan.

12          “(2) FEE.—The Secretary shall require a  
13          \$5,000 fee for the original certification under para-  
14          graph (1) and may charge a reasonable annual fee  
15          to cover the costs of processing and reviewing the  
16          annual statements of the plan.

17          “(3) EXPEDITED PROCEDURES.—The Secretary  
18          may by regulation provide for expedited registration,  
19          certification, and comment procedures.

20          “(4) AGREEMENTS.—The Secretary of Labor  
21          may enter into agreements with the States to carry  
22          out the Secretary’s responsibilities under this sub-  
23          chapter.

24          “(d) AVAILABILITY.—Notwithstanding any other  
25          provision of this chapter, a qualified association plan may

1 limit coverage to individuals who are members of the  
 2 qualified association establishing or maintaining the plan,  
 3 an employee of such member, or a dependent of either.

4 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the  
 5 case of a plan in existence on January 1, 2001—

6 “(1) the requirements of subsection (a) (other  
 7 than paragraphs (4), (5), and (6) thereof) shall not  
 8 apply;

9 “(2) no original certification shall be required  
 10 under this subchapter; and

11 “(3) no annual report or funding statement  
 12 shall be required before January 1, 2003, but the  
 13 plan shall file with the Secretary a description of the  
 14 plan and the name of the health insurance issuer.

15 **“SEC. 2709B. DEFINITIONS AND SPECIAL RULES.**

16 “(a) QUALIFIED ASSOCIATION.—For purposes of this  
 17 subchapter, the term ‘qualified association’ means any or-  
 18 ganization which—

19 “(1) is organized and maintained in good faith  
 20 by a trade association, an industry association, a  
 21 professional association, a chamber of commerce, a  
 22 religious organization, a public entity association, or  
 23 other business association serving a common or simi-  
 24 lar industry;

1           “(2) is organized and maintained for substan-  
2           tial purposes other than to provide a health plan;

3           “(3) has a constitution, bylaws, or other similar  
4           governing document which states its purpose; and

5           “(4) receives a substantial portion of its finan-  
6           cial support from its active, affiliated, or federation  
7           members.

8           “(b) COORDINATION.—The term ‘qualified associa-  
9           tion plan’ shall not include a plan to which subchapter  
10          B applies.

11       **“SEC. 2709C. SPECIAL RULE FOR CHURCH, MULTIEM-**  
12                               **PLOYER, AND COOPERATIVE PLANS.**

13           “(a) GENERAL RULE.—For purposes of this chapter,  
14           in the case of a group health plan to which this section  
15           applies—

16           “(1) except as otherwise provided in this sub-  
17           chapter, the plan shall be required to meet all appli-  
18           cable requirements of subchapter A and subchapter  
19           B for group health plans offered to and by small em-  
20           ployers;

21           “(2) if such plan is certified as meeting such  
22           requirements, such plan shall be treated as a plan  
23           established and maintained by a small employer and  
24           individuals enrolled in such plan shall be treated as  
25           eligible employees; and

1           “(3) any individual eligible to enroll in the plan  
2           who does not enroll in the plan shall not be treated  
3           as an eligible employee solely by reason of being eli-  
4           gible to enroll in the plan.

5           “(b) MODIFIED STANDARDS.—

6           “(1) CERTIFYING AUTHORITY.—For purposes  
7           of this chapter, the Secretary shall be the appro-  
8           priate certifying authority with respect to a plan to  
9           which this section applies.

10           “(2) AVAILABILITY.—Rules similar to the rules  
11           of subsection (e) of section 2709A shall apply to a  
12           plan to which this section applies.

13           “(3) ACCESS.—An employer which, pursuant to  
14           a collective bargaining agreement, offers an em-  
15           ployee the opportunity to enroll in a plan described  
16           in subsection (c)(2) shall not be required to make  
17           any other plan available to the employee.

18           “(4) TREATMENT UNDER STATE LAWS.—A  
19           church plan described in subsection (c)(1) which is  
20           certified as meeting the requirements of this section  
21           shall not be deemed to be a multiple employer wel-  
22           fare arrangement or an insurance company or other  
23           insurer, or to be engaged in the business of insur-  
24           ance, for purposes of any State law purporting to  
25           regulate insurance companies or insurance contracts.



1       “(c) PLANS TO WHICH SECTION APPLIES.—This sec-  
2       tion shall apply to a health plan which—

3               “(1) is a church plan (as defined in section  
4               414(e) of the Internal Revenue Code of 1986) which  
5               has at least 100 participants in the United States;

6               “(2) is a multiemployer plan which is main-  
7               tained by a health plan sponsor described in section  
8               3(16)(B)(iii) of the Employee Retirement Income  
9               Security Act of 1974 and which has at least 500  
10              participants in the United States; or

11              “(3) is a plan which is maintained by a rural  
12              electric cooperative or a rural telephone cooperative  
13              association and which has at least 500 participants  
14              in the United States.”.

15       (b) CONFORMING AMENDMENTS.—Section 2791(d)  
16       of the Public Health Service Act (42 U.S.C. 300gg–91(d))  
17       is amended by adding at the end the following:

18              “(15) ELIGIBLE EMPLOYEE.—The term ‘eligible  
19              employee’ means, with respect to an employer, an  
20              employee who normally performs on a monthly basis  
21              at least 30 hours of service per week for that em-  
22              ployer.

23              “(16) ELIGIBLE INDIVIDUAL.—The term ‘eligi-  
24              ble individual’ means, with respect to an eligible em-

1        ployee, such employee, and any dependent of such  
2        employee.

3            “(17) NAIC.—The term ‘NAIC’ means the Na-  
4        tional Association of Insurance Commissioners.

5            “(18) QUALIFIED GROUP HEALTH PLAN.—The  
6        term ‘qualified group health plan’ shall have the  
7        meaning given the term in section 2707.”.

8        **SEC. 403. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
9            **ACT RELATING TO THE INDIVIDUAL MARKET.**

10        The first subpart 3 of part B of title XXVII of the  
11        Public Health Service Act (42 U.S.C. 300gg-51 et seq.)  
12        is amended—

13            (1) by redesignating such subpart as subpart 2;  
14        and

15            (2) by adding at the end the following:

16        **“SEC. 2753. APPLICABILITY OF GENERAL INSURANCE MAR-**  
17            **KET REFORMS.**

18        “The provisions of chapter 2 of subpart 2 of part A  
19        shall apply to health insurance coverage offered by a  
20        health insurance issuer in the individual market in the  
21        same manner as they apply to health insurance coverage  
22        offered by a health insurance issuer in connection with a  
23        group health plan in the small or large group market.”.

1 **SEC. 404. EFFECTIVE DATE.**

2       The amendments made by this subtitle shall apply  
3 with respect to health insurance coverage offered, sold,  
4 issued, renewed, in effect, or operated on or after January  
5 1, 2002.

6                   **Subtitle B—Tax Provisions**

7 **SEC. 411. ENFORCEMENT WITH RESPECT TO HEALTH IN-**  
8 **SURANCE ISSUERS.**

9       (a) IN GENERAL.—Chapter 43 of the Internal Rev-  
10 enue Code of 1986 (relating to qualified pension, etc.,  
11 plans) is amended by adding at the end the following:

12 **“SEC. 4980F. FAILURE OF INSURER TO COMPLY WITH CER-**  
13 **TAIN STANDARDS FOR HEALTH INSURANCE**  
14 **COVERAGE.**

15       “(a) IMPOSITION OF TAX.—

16               “(1) IN GENERAL.—There is hereby imposed a  
17 tax on the failure of a health insurance issuer to  
18 comply with the requirements applicable to such  
19 issuer under—

20               “(A) chapter 2 of subpart 2 of part A of  
21 title XXVII of the Public Health Service Act;

22               “(B) section 2753 of the Public Health  
23 Service Act; and

24               “(C) subpart C of part 7 of subtitle B of  
25 title I of the Employee Retirement Income Se-  
26 curity Act of 1974.

1           “(2) EXCEPTION.—Paragraph (1) shall not  
 2       apply to a failure by a health insurance issuer in a  
 3       State if the Secretary of Health and Human Serv-  
 4       ices determines that the State has in effect a regu-  
 5       latory enforcement mechanism that provides ade-  
 6       quate sanctions with respect to such a failure by  
 7       such an issuer.

8       “(b) AMOUNT OF TAX.—

9           “(1) IN GENERAL.—Subject to paragraph (2),  
 10      the amount of the tax imposed by subsection (a)  
 11      shall be \$100 for each day during which such failure  
 12      persists for each person to which such failure re-  
 13      lates. A rule similar to the rule of section  
 14      4980D(b)(3) shall apply for purposes of this section.

15          “(2) LIMITATION.—The amount of the tax im-  
 16      posed by subsection (a) for a health insurance issuer  
 17      with respect to health insurance coverage shall not  
 18      exceed 25 percent of the amounts received under the  
 19      coverage for coverage during the period such failure  
 20      persists.

21          “(c) LIABILITY FOR TAX.—The tax imposed by this  
 22      section shall be paid by the health insurance issuer.

23          “(d) LIMITATIONS ON AMOUNT OF TAX.—

1           “(1) TAX NOT TO APPLY TO FAILURES COR-  
 2           RECTED WITHIN 30 DAYS.—No tax shall be imposed  
 3           by subsection (a) on any failure if—

4                   “(A) such failure was due to reasonable  
 5                   cause and not to willful neglect, and

6                   “(B) such failure is corrected during the  
 7                   30-day period (or such period as the Secretary  
 8                   may determine appropriate) beginning on the  
 9                   first date the health insurance issuer knows, or  
 10                  exercising reasonable diligence could have  
 11                  known, that such failure existed.

12           “(2) WAIVER BY SECRETARY.—In the case of a  
 13           failure which is due to reasonable cause and not to  
 14           willful neglect, the Secretary may waive part or all  
 15           of the tax imposed by subsection (a) to the extent  
 16           that the payment of such tax would be excessive rel-  
 17           ative to the failure involved.

18           “(e) DEFINITIONS.—For purposes of this section, the  
 19           terms ‘health insurance coverage’ and ‘health insurance  
 20           issuer’ have the meanings given such terms in section  
 21           2791 of the Public Health Service Act and section 733  
 22           of the Employee Retirement Income Security Act of  
 23           1974.”.

1 (b) CONFORMING AMENDMENT.—The table of sec-  
 2 tions for such chapter 43 is amended by adding at the  
 3 end the following new item:

“Sec. 4980F. Failure of insurer to comply with certain standards  
 for health insurance coverage.”.

4 **SEC. 412. ENFORCEMENT WITH RESPECT TO SMALL EM-**  
 5 **LOYERS.**

6 (a) IN GENERAL.—Chapter 47 of the Internal Rev-  
 7 enue Code of 1986 (relating to excise taxes on certain  
 8 group health plans) is amended by inserting after section  
 9 5000 the following new section:

10 **“SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.**

11 “(a) GENERAL RULE.—There is hereby imposed a  
 12 tax on the failure of any small employer to comply with  
 13 the requirements applicable to such employer under—

14 “(1) subchapter C of chapter 2 of subpart 2 of  
 15 part A of title XXVII of the Public Health Service  
 16 Act;

17 “(2) section 2753 of the Public Health Service  
 18 Act; and

19 “(3) chapter 2 of subpart C of part 7 of sub-  
 20 title B of title I of the Employee Retirement Income  
 21 Security Act of 1974.

22 “(b) AMOUNT OF TAX.—The amount of tax imposed  
 23 by subsection (a) shall be equal to \$100 for each day for  
 24 each individual for which such a failure occurs.

1 “(c) LIMITATION ON TAX.—

2 “(1) TAX NOT TO APPLY WHERE FAILURES  
3 CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
4 posed by subsection (a) with respect to any failure  
5 if—

6 “(A) such failure was due to reasonable  
7 cause and not to willful neglect, and

8 “(B) such failure is corrected during the  
9 30-day period (or such period as the Secretary  
10 may determine appropriate) beginning on the  
11 1st date any of the individuals on whom the tax  
12 is imposed knew, or exercising reasonable dili-  
13 gence would have known, that such failure ex-  
14 isted.

15 “(2) WAIVER BY SECRETARY.—In the case of a  
16 failure which is due to reasonable cause and not to  
17 willful neglect, the Secretary may waive part or all  
18 of the tax imposed by subsection (a) to the extent  
19 that the payment of such tax would be excessive rel-  
20 ative to the failure involved.”.

21 (b) CONFORMING AMENDMENT.—The table of sec-  
22 tions for such chapter 47 is amended by adding at the  
23 end the following new item:

“Sec. 5000A. Small employer requirements.”.

1 **SEC. 413. ENFORCEMENT BY EXCISE TAX ON QUALIFIED AS-**  
 2 **SOCIATIONS.**

3 (a) IN GENERAL.—Chapter 43 of the Internal Rev-  
 4 enue Code of 1986 (relating to qualified pension, etc.,  
 5 plans), as amended by section 411, is amended by adding  
 6 at the end the following new section:

7 **“SEC. 4980G. FAILURE OF QUALIFIED ASSOCIATIONS, ETC.,**  
 8 **TO COMPLY WITH CERTAIN STANDARDS FOR**  
 9 **HEALTH INSURANCE COVERAGE.**

10 “(a) IMPOSITION OF TAX.—

11 “(1) IN GENERAL.—There is hereby imposed a  
 12 tax on the failure of a qualified association (as de-  
 13 fined in section 2709A of the Public Health Service  
 14 Act and section 723A of the Employee Retirement  
 15 Income Security Act of 1974), church plan (as de-  
 16 fined in section 414(e)), multiemployer plan, or plan  
 17 maintained by a rural electric cooperative or a rural  
 18 telephone cooperative association (within the mean-  
 19 ing of section 3(40) of the Employee Retirement In-  
 20 come Security Act of 1974) to comply with the re-  
 21 quirements applicable to such association or plans  
 22 under—

23 “(A) subchapter C of chapter 2 of subpart  
 24 2 of part A of title XXVII of the Public Health  
 25 Service Act;



1           “(B) section 2753 of the Public Health  
2           Service Act; and

3           “(C) subchapters A and B of chapter 3 of  
4           subpart C of part 7 of the Employee Retirement  
5           Income Security Act of 1974.

6           “(2) EXCEPTION.—Paragraph (1) shall not  
7           apply to a failure by a qualified association, church  
8           plan, multiemployer plan, or plan maintained by a  
9           rural electric cooperative or a rural telephone coop-  
10          erative association in a State if the Secretary of  
11          Health and Human Services determines that the  
12          State has in effect a regulatory enforcement mecha-  
13          nism that provides adequate sanctions with respect  
14          to such a failure by such a qualified association or  
15          plan.

16          “(b) AMOUNT OF TAX.—The amount of the tax im-  
17          posed by subsection (a) shall be \$100 for each day during  
18          which such failure persists for each person to which such  
19          failure relates. A rule similar to the rule of section  
20          4980D(b)(3) shall apply for purposes of this section.

21          “(c) LIABILITY FOR TAX.—The tax imposed by this  
22          section shall be paid by the qualified association or plan.

23          “(d) LIMITATIONS ON AMOUNT OF TAX.—

1           “(1) TAX NOT TO APPLY TO FAILURES COR-  
 2       RECTED WITHIN 30 DAYS.—No tax shall be imposed  
 3       by subsection (a) on any failure if—

4           “(A) such failure was due to reasonable  
 5       cause and not to willful neglect, and

6           “(B) such failure is corrected during the  
 7       30-day period (or such period as the Secretary  
 8       may determine appropriate) beginning on the  
 9       first date the qualified association, church plan,  
 10      multiemployer plan, or plan maintained by a  
 11      rural electric cooperative or a rural telephone  
 12      cooperative association knows, or exercising rea-  
 13      sonable diligence could have known, that such  
 14      failure existed.

15          “(2) WAIVER BY SECRETARY.—In the case of a  
 16      failure which is due to reasonable cause and not to  
 17      willful neglect, the Secretary may waive part or all  
 18      of the tax imposed by subsection (a) to the extent  
 19      that the payment of such tax would be excessive rel-  
 20      ative to the failure involved.”.

21          (b) CONFORMING AMENDMENT.—The table of sec-  
 22      tions for such chapter 43, as amended by section 411, is  
 23      amended by adding at the end the following new item:

          “Sec. 4980G. Failure of qualified associations, etc., to comply  
           with certain standards for health insurance plans.”.

1 **SEC. 414. DEDUCTION FOR HEALTH INSURANCE COSTS OF**  
 2 **SELF-EMPLOYED INDIVIDUALS.**

3 (a) FULL DEDUCTION IN 2002.—The table contained  
 4 in section 162(l)(1)(B) of the Internal Revenue Code of  
 5 1986 (relating to special rules for health insurance costs  
 6 of self-employed individuals) is amended—

- 7 (1) by striking “2001” and inserting “2000”;  
 8 (2) by striking “2002” and all that follows; and  
 9 (3) by adding at the end the following:

“2001 .....	70
“2002 and thereafter .....	100.”.

10 (b) EFFECTIVE DATE.—The amendments made by  
 11 this section shall apply to taxable years beginning after  
 12 December 31, 2000.

13 **SEC. 415. AMENDMENTS TO COBRA.**

14 (a) AMENDMENTS TO INTERNAL REVENUE CODE OF  
 15 1986.—

16 (1) LOWER COST COVERAGE OPTIONS.—Sub-  
 17 paragraph (A) of section 4980B(f)(2) of the Internal  
 18 Revenue Code of 1986 (relating to continuation cov-  
 19 erage requirements of group health plans) is amend-  
 20 ed to read as follows:

21 “(A) TYPE OF BENEFIT COVERAGE.—The  
 22 coverage must consist of coverage which, as of  
 23 the time the coverage is being provided—

1 “(i) is identical to the coverage pro-  
 2 vided under the plan to similarly situated  
 3 beneficiaries under the plan with respect to  
 4 whom a qualifying event has not occurred,

5 “(ii) is so identical, except such cov-  
 6 erage is offered with an annual \$1,000 de-  
 7 ductible, and

8 “(iii) is so identical, except such cov-  
 9 erage is offered with an annual \$3,000 de-  
 10 ductible.

11 If coverage under the plan is modified for any  
 12 group of similarly situated beneficiaries, the  
 13 coverage shall also be modified in the same  
 14 manner for all individuals who are qualified  
 15 beneficiaries under the plan pursuant to this  
 16 subsection in connection with such group.”.

17 (2) TERMINATION OF COBRA COVERAGE AFTER  
 18 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
 19 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the  
 20 Internal Revenue Code of 1986 (relating to period of  
 21 coverage) is amended—

22 (A) by striking “or” at the end of sub-  
 23 clause (I);

24 (B) by redesignating subclause (II) as sub-  
 25 clause (III); and

1 (C) by inserting after subclause (I) the fol-  
 2 lowing:

3 “(II) eligible for such employer-  
 4 based coverage for more than 90 days,  
 5 or”.

6 (3) REDUCTION OF PERIOD OF COVERAGE.—  
 7 Clause (i) of section 4980B(f)(2)(B) of the Internal  
 8 Revenue Code of 1986 (relating to period of cov-  
 9 erage) is amended by striking “18 months” each  
 10 place it appears and inserting “24 months”.

11 (4) CONTINUATION COVERAGE FOR DEPENDENT  
 12 CHILD.—Clause (i) of section 4980B(f)(2)(B) of the  
 13 Internal Revenue Code of 1986 is amended by add-  
 14 ing at the end the following:

15 “(VI) SPECIAL RULE FOR DE-  
 16 PENDENT CHILD.—In the case of a  
 17 qualifying event described in para-  
 18 graph (3)(E), the date that is 36  
 19 months after the date on which the  
 20 dependent child of the covered em-  
 21 ployee ceases to be a dependent child  
 22 under the plan.”.

23 (b) AMENDMENTS TO EMPLOYEE RETIREMENT IN-  
 24 COME SECURITY ACT OF 1974.—

1           (1) LOWER COST COVERAGE OPTIONS.—Para-  
 2           graph (1) of section 602 of the Employee Retire-  
 3           ment Income Security Act of 1974 (29 U.S.C.  
 4           1162(1)) (relating to continuation coverage require-  
 5           ments of group health plans) is amended to read as  
 6           follows:

7           “(1) TYPE OF BENEFIT COVERAGE.—The cov-  
 8           erage must consist of coverage which, as of the time  
 9           the coverage is being provided—

10           “(A) is identical to the coverage provided  
 11           under the plan to similarly situated bene-  
 12           ficiaries under the plan with respect to whom a  
 13           qualifying event has not occurred,

14           “(B) is so identical, except such coverage  
 15           is offered with an annual \$1,000 deductible,  
 16           and

17           “(C) is so identical, except such coverage is  
 18           offered with an annual \$3,000 deductible.

19           If coverage under the plan is modified for any group  
 20           of similarly situated beneficiaries, the coverage shall  
 21           also be modified in the same manner for all individ-  
 22           uals who are qualified beneficiaries under the plan  
 23           pursuant to this subsection in connection with such  
 24           group.”.

1           (2) TERMINATION OF COBRA COVERAGE AFTER  
2           ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
3           DAYS.—Subparagraph (D) of section 602(2) of the  
4           Employee Retirement Income Security Act of 1974  
5           (29 U.S.C. 1162(2)(D)) (relating to period of cov-  
6           erage) is amended—

7                   (A) by striking “or” at the end of clause  
8                   (i);

9                   (B) by redesignating clause (ii) as clause  
10                  (iii); and

11                  (C) by inserting after clause (i) the fol-  
12                  lowing:

13                           “(ii) eligible for such employer-based  
14                           coverage for more than 90 days, or”.

15           (3) REDUCTION OF PERIOD OF COVERAGE.—  
16           Subparagraph (A) of section 602(2) of the Employee  
17           Retirement Income Security Act of 1974 (29 U.S.C.  
18           1162(2)(A)) (relating to period of coverage) is  
19           amended by striking “18 months” each place it ap-  
20           pears and inserting “24 months”.

21           (4) CONTINUATION COVERAGE FOR DEPENDENT  
22           CHILD.—Subparagraph (A) of section 602(2) of the  
23           Employee Retirement Income Security Act of 1974  
24           (29 U.S.C. 1162(2)(A)) is amended by adding at the  
25           end the following:

1                   “(vi) SPECIAL RULE FOR DEPENDENT  
 2                   CHILD.—In the case of a qualifying event  
 3                   described in section 603(5), the date that  
 4                   is 36 months after the date on which the  
 5                   dependent child of the covered employee  
 6                   ceases to be a dependent child under the  
 7                   plan.”.

8           (c) AMENDMENTS TO PUBLIC HEALTH SERVICE  
 9 ACT.—

10           (1) LOWER COST COVERAGE OPTIONS.—Para-  
 11           graph (1) of section 2202 of the Public Health Serv-  
 12           ice Act (42 U.S.C. 300bb-2(1)) (relating to continu-  
 13           ation coverage requirements of group health plans)  
 14           is amended to read as follows:

15           “(1) TYPE OF BENEFIT COVERAGE.—The cov-  
 16           erage must consist of coverage which, as of the time  
 17           the coverage is being provided—

18                   “(A) is identical to the coverage provided  
 19                   under the plan to similarly situated bene-  
 20                   ficiaries under the plan with respect to whom a  
 21                   qualifying event has not occurred,

22                   “(B) is so identical, except such coverage  
 23                   is offered with an annual \$1,000 deductible,  
 24                   and



1           “(C) is so identical, except such coverage is  
2           offered with an annual \$3,000 deductible.

3           If coverage under the plan is modified for any group  
4           of similarly situated beneficiaries, the coverage shall  
5           also be modified in the same manner for all individ-  
6           uals who are qualified beneficiaries under the plan  
7           pursuant to this subsection in connection with such  
8           group.”.

9           (2) TERMINATION OF COBRA COVERAGE AFTER  
10          ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
11          DAYS.—Subparagraph (D) of section 2202(2) of the  
12          Public Health Service Act (42 U.S.C. 300bb-  
13          2(2)(D)) (relating to period of coverage) is  
14          amended—

15                 (A) by striking “or” at the end of clause  
16                 (i);

17                 (B) by redesignating clause (ii) as clause  
18                 (iii); and

19                 (C) by inserting after clause (i) the fol-  
20          lowing:

21                         “(ii) eligible for such employer-based  
22                         coverage for more than 90 days, or”.

23          (3) REDUCTION OF PERIOD OF COVERAGE.—  
24          Subparagraph (A) of section 2202(2) of the Public  
25          Health Service Act (42 U.S.C. 300bb-2(2)(A)) (re-

1       lating to period of coverage) is amended by striking  
 2       “18 months” each place it appears and inserting  
 3       “24 months”.

4               (4) CONTINUATION COVERAGE FOR DEPENDENT  
 5       CHILD.—Subparagraph (A) of section 2202(2) of the  
 6       Public Health Service Act (42 U.S.C. 300bb-  
 7       2(2)(A)) is amended by adding at the end the fol-  
 8       lowing:

9                       “(vi) SPECIAL RULE FOR DEPENDENT  
 10                      CHILD.—In the case of a qualifying event  
 11                      described in section 2203(5), the date that  
 12                      is 36 months after the date on which the  
 13                      dependent child of the covered employee  
 14                      ceases to be a dependent child under the  
 15                      plan.”.

16       (d) EFFECTIVE DATE.—The amendments made by  
 17       this section shall apply to qualifying events occurring after  
 18       the date of the enactment of this Act.

## 19                   **TITLE V—PRIMARY AND** 20                   **PREVENTIVE CARE SERVICES**

### 21       **SEC. 501. IMPROVEMENT OF MEDICARE PREVENTIVE CARE** 22                   **SERVICES.**

23       (a) WAIVER OF COINSURANCE FOR SCREENING AND  
 24       DIAGNOSTIC MAMMOGRAPHY.—

1           (1) IN GENERAL.—Section 1833(a)(1) of the  
 2       Social Security Act (42 U.S.C. 1395l(a)(1)), as  
 3       amended by section 223(c) of the Medicare, Med-  
 4       icaid, and SCHIP Benefits Improvement and Pro-  
 5       tection Act of 2000 (as enacted into law by section  
 6       1(a)(6) of Public Law 106–554), is amended—

7                   (A) by striking “and (U)” and inserting  
 8                   “(U)”; and

9                   (B) by striking the semicolon at the end  
 10          and inserting the following: “, and (V) with re-  
 11          spect to screening mammography (as defined in  
 12          section 1861(jj)) and diagnostic mammography,  
 13          100 percent of the payment basis determined  
 14          under section 1848;”.

15          (2) WAIVER OF COINSURANCE IN OUTPATIENT  
 16          HOSPITAL SETTINGS.—The third sentence of section  
 17          1866(a)(2)(A) of the Social Security Act (42 U.S.C.  
 18          1395cc(a)(2)(A)) is amended by inserting after  
 19          “1861(s)(10)(A)” the following: “, with respect to  
 20          screening mammography (as defined in section  
 21          1861(jj)) and diagnostic mammography,”.

22          (b) COVERAGE OF INSULIN PUMPS.—

23                  (1) INCLUSION AS ITEM OF DURABLE MEDICAL  
 24          EQUIPMENT.—Section 1861(n) of the Social Secu-  
 25          rity Act (42 U.S.C. 1395x(n)) is amended by insert-

1       ing before the semicolon the following: “, and in-  
 2       cludes insulin infusion pumps (as defined in sub-  
 3       section (ww)) prescribed by the physician of an indi-  
 4       vidual with Type I diabetes who is experiencing se-  
 5       vere swings of high and low blood glucose levels and  
 6       has successfully completed a training program that  
 7       meets standards established by the Secretary or who  
 8       has used such a pump without interruption for at  
 9       least 18 months immediately before enrollment  
 10      under part B”.

11           (2) DEFINITION OF INSULIN INFUSION PUMP.—  
 12      Section 1861 of the Social Security Act (42 U.S.C.  
 13      1395x), as amended by section 105(b) of the Medi-  
 14      care, Medicaid, and SCHIP Benefits Improvement  
 15      and Protection Act of 2000 (as enacted into law by  
 16      section 1(a)(6) of Public Law 106–554), is amended  
 17      by adding at the end the following:

18                   “Insulin Infusion Pump  
 19      “(ww) The term ‘insulin infusion pump’ means an in-  
 20      fusion pump, approved by the Federal Food and Drug Ad-  
 21      ministration, that provides for the computerized delivery  
 22      of insulin for individuals with diabetes in lieu of multiple  
 23      daily manual insulin injections.”.

24           (3) PAYMENT FOR SUPPLIES RELATING TO IN-  
 25      FUSION PUMPS.—Section 1834(a)(2)(A) of the So-

1       cial Security Act (42 U.S.C. 1395m(a)(2)(A)) is  
2       amended—

3               (A) in clause (ii), by striking “or” at the  
4       end;

5               (B) in clause (iii), by inserting “or” at the  
6       end; and

7               (C) by inserting after clause (iii) the fol-  
8       lowing:

9                       “(iv) which is an accessory used in  
10               conjunction with an insulin infusion pump  
11               (as defined in section 1861(w)),”.

12       (c) ANNUAL SCREENING PAP SMEAR AND PELVIC  
13 EXAMS.—

14               (1) IN GENERAL.—Section 1861(nn) of the So-  
15       cial Security Act (42 U.S.C. 1395x(nn)), as amended  
16       by section 101(a) of the Medicare, Medicaid, and  
17       SCHIP Benefits Improvement and Protection Act of  
18       2000 (as enacted into law by section 1(a)(6) of Pub-  
19       lic Law 106–554), is amended to read as follows:

20       “Screening Pap Smear; Screening Pelvic Exam

21       “(nn)(1) The term ‘screening pap smear’ means a di-  
22       agnostic laboratory test consisting of a routine exfoliative  
23       cytology test (Papanicolaou test) provided to a woman for  
24       the purpose of early detection of cervical or vaginal cancer  
25       and includes a physician’s interpretation of the results of

1 the test, if the individual involved has not had such a test  
 2 during the preceding year.

3 “(2) The term ‘screening pelvic exam’ means a pelvic  
 4 examination provided to a woman if the woman involved  
 5 has not had such an examination during the preceding  
 6 year, and includes a clinical breast examination, relevant  
 7 history-taking, medical decision-making, and patient coun-  
 8 seling.”.

9 (2) WAIVER OF COINSURANCE FOR PELVIC  
 10 EXAMS.—Section 1833(a)(1) of the Social Security  
 11 Act (42 U.S.C. 1395l(a)(1)), as amended by sub-  
 12 section (a)(1) and section 223(c) of the Medicare,  
 13 Medicaid, and SCHIP Benefits Improvement and  
 14 Protection Act of 2000 (as enacted into law by sec-  
 15 tion 1(a)(6) of Public Law 106–554), is amended—

16 (A) by striking “and (V)” and inserting  
 17 “(V)”; and

18 (B) by striking the semicolon at the end  
 19 and inserting the following: “, and (W) with re-  
 20 spect to services described in section  
 21 1861(n)(2), 100 percent of the payment basis  
 22 determined under section 1848;”.

23 (e) EFFECTIVE DATE.—The amendments made by  
 24 this section shall apply to items and services furnished on  
 25 or after the first day of the first calendar quarter begin-

1 ning on or after the date that is 6 months after the date  
 2 of enactment of this Act.

3 **SEC. 502. AUTHORIZATION OF APPROPRIATIONS FOR**  
 4 **HEALTHY START PROGRAM.**

5 (a) AUTHORIZATION OF APPROPRIATIONS.—To en-  
 6 able the Secretary of Health and Human Services to carry  
 7 out the healthy start program established under the au-  
 8 thority of section 301 of the Public Health Service Act  
 9 (42 U.S.C. 241), there are authorized to be appropriated  
 10 \$115,000,000 for fiscal year 2002, \$150,000,000 for fis-  
 11 cal year 2003, \$250,000,000 for fiscal year 2004, and  
 12 \$300,000,000 for each of the fiscal years 2005 through  
 13 2007.

14 (b) MODEL PROJECTS.—

15 (1) IN GENERAL.—Of the amount appropriated  
 16 under subsection (a) for a fiscal year, the Secretary  
 17 of Health and Human Services shall reserve  
 18 \$50,000,000 for such fiscal year to be distributed to  
 19 model projects determined to be eligible under para-  
 20 graph (2).

21 (2) ELIGIBILITY.—To be eligible to receive  
 22 funds under paragraph (1), a model project shall—

23 (A) have been one of the original 15  
 24 Healthy Start projects; and

1 (B) be determined by Secretary of Health  
2 and Human Services to have been successful in  
3 serving needy areas and reducing infant mor-  
4 tality.

5 (3) USE OF PROJECTS.—A model project that  
6 receives funding under paragraph (1) shall be uti-  
7 lized as a resource center to assist in the training  
8 of those individuals to be involved in projects estab-  
9 lished under subsection (c). It shall be the goal of  
10 such projects to become self-sustaining within the  
11 project area.

12 (4) PROVISION OF MATCHING FUNDS.—In pro-  
13 viding assistance to a project under this subsection,  
14 the Secretary of Health and Human Services shall  
15 ensure that—

16 (A) with respect to fiscal year 2002, the  
17 project shall make non-Federal contributions  
18 (in cash or in-kind) towards the costs of such  
19 project in an amount equal to not less than 20  
20 percent of such costs;

21 (B) with respect to fiscal year 2003, the  
22 project shall make non-Federal contributions  
23 (in cash or in-kind) towards the costs of such  
24 project in an amount equal to not less than 30  
25 percent of such costs;



1 (C) with respect to fiscal year 2004, the  
2 project shall make non-Federal contributions  
3 (in cash or in-kind) towards the costs of such  
4 project in an amount equal to not less than 40  
5 percent of such costs; and

6 (D) with respect to each of the fiscal years  
7 2005 through 2007, the project shall make non-  
8 Federal contributions (in cash or in-kind) to-  
9 wards the costs of such project in an amount  
10 equal to not less than 50 percent of such costs  
11 for each such fiscal year.

12 (c) NEW PROJECTS.—Of the amount appropriated  
13 under subsection (a) for a fiscal year, the Secretary of  
14 Health and Human Services shall allocate amounts re-  
15 maining after the reservation under subsection (b) for  
16 such fiscal year among new demonstration projects and  
17 existing special projects that have proven to be successful  
18 as determined by the Secretary of Health and Human  
19 Services. Such projects shall be community-based and  
20 shall attempt to replicate healthy start model projects that  
21 have been determined by the Secretary of Health and  
22 Human Services to be successful.

1 **SEC. 503. REAUTHORIZATION OF CERTAIN PROGRAMS PRO-**  
 2 **VIDING PRIMARY AND PREVENTIVE CARE.**

3 (a) TUBERCULOSIS PREVENTION GRANTS.—Section  
 4 317(j)(1) of the Public Health Service Act (42 U.S.C.  
 5 247b(j)(1)), as amended by section 1711 of the Children’s  
 6 Health Act of 2000 (Public Law 106-310), is amended  
 7 by striking “2005” and inserting “2007”.

8 (b) SEXUALLY TRANSMITTED DISEASES.—Section  
 9 318(e)(1) of the Public Health Service Act (42 U.S.C.  
 10 247c(e)(1)) is amended—

11 (1) by striking “and such sums” and inserting  
 12 “such sums”;

13 (2) by striking “1998” and inserting “2001”;  
 14 and

15 (3) by inserting before the period the following:  
 16 “, \$130,000,000 for each of the fiscal years 2002  
 17 and 2003, and such sums as may be necessary for  
 18 each of the fiscal years 2004 through 2006”.

19 (c) FAMILY PLANNING PROJECT GRANTS.—Section  
 20 1001(d) of the Public Health Service Act (42 U.S.C.  
 21 300(d)) is amended—

22 (1) by striking “and \$158,400,000” and insert-  
 23 ing “\$158,400,000”; and

24 (2) by inserting before the period the following:  
 25 “; \$430,000,000 for fiscal year 2002; and such sums

1 as may be necessary for each of the fiscal years  
 2 2003 through 2005”.

3 (d) BREAST AND CERVICAL CANCER PREVENTION.—  
 4 Section 1510(a) of the Public Health Service Act (42  
 5 U.S.C. 300n–5(a)) is amended—

6 (1) by striking “and such sums” and inserting  
 7 “such sums”; and

8 (2) by inserting before the period the following:  
 9 “, \$200,000,000 for fiscal year 2002, and such sums  
 10 as may be necessary for each of the fiscal years  
 11 2003 through 2005”.

12 (e) PREVENTIVE HEALTH AND HEALTH SERVICES  
 13 BLOCK GRANT.—Section 1901(a) of the Public Health  
 14 Service Act (42 U.S.C. 300w(a)) is amended by striking  
 15 “\$205,000,000” and inserting “\$235,000,000”.

16 (f) MATERNAL AND CHILD HEALTH SERVICES  
 17 BLOCK GRANT.—Section 501(a) of the Social Security  
 18 Act (42 U.S.C. 701(a)) is amended by striking “fiscal year  
 19 2001 and each fiscal year thereafter” and inserting “each  
 20 of fiscal years 2001 and 2002, and such sums as may be  
 21 necessary for each of the fiscal years 2003 through 2005”.

22 **SEC. 504. COMPREHENSIVE SCHOOL HEALTH EDUCATION**  
 23 **PROGRAM.**

24 (a) PURPOSE.—It is the purpose of this section to  
 25 establish a comprehensive school health education and pre-

1 vention program for elementary and secondary school stu-  
2 dents.

3 (b) PROGRAM AUTHORIZED.—The Secretary of Edu-  
4 cation (referred to in this section as the “Secretary”),  
5 through the Office of Comprehensive School Health Edu-  
6 cation established in subsection (e), shall award grants to  
7 States from allotments under subsection (c) to enable such  
8 States to—

9 (1) award grants to local or intermediate edu-  
10 cational agencies, and consortia thereof, to enable  
11 such agencies or consortia to establish, operate, and  
12 improve local programs of comprehensive health edu-  
13 cation and prevention, early health intervention, and  
14 health education, in elementary and secondary  
15 schools (including preschool, kindergarten, inter-  
16 mediate, and junior high schools); and

17 (2) develop training, technical assistance, and  
18 coordination activities for the programs assisted pur-  
19 suant to paragraph (1).

20 (c) RESERVATIONS AND STATE ALLOTMENTS.—

21 (1) RESERVATIONS.—From the sums appro-  
22 priated pursuant to the authority of subsection (f)  
23 for any fiscal year, the Secretary shall reserve—

24 (A) 1 percent for payments to Guam,  
25 American Samoa, the Virgin Islands, the Re-

public of the Marshall Islands, the Federated States of Micronesia, the Northern Mariana Islands, and the Republic of Palau, to be allotted in accordance with their respective needs; and

(B) 1 percent for payments to the Bureau of Indian Affairs.

(2) STATE ALLOTMENTS.—From the remainder of the sums not reserved under paragraph (1), the Secretary shall allot to each State an amount which bears the same ratio to the amount of such remainder as the school-age population of the State bears to the school-age population of all States, except that no State shall be allotted less than an amount equal to 0.5 percent of such remainder.

(3) REALLOTMENT.—The Secretary may reallocate any amount of any allotment to a State to the extent that the Secretary determines that the State will not be able to obligate such amount within 2 years of allotment. Any such reallocation shall be made on the same basis as an allotment under paragraph (2).

(d) USE OF FUNDS.—Grant funds provided to local or intermediate educational agencies, or consortia thereof, under this section may be used to improve elementary and secondary education in the areas of—

(1) personal health and fitness;

- 1           (2) prevention of chronic diseases;
- 2           (3) prevention and control of communicable dis-
- 3       eases;
- 4           (4) nutrition;
- 5           (5) substance use and abuse;
- 6           (6) accident prevention and safety;
- 7           (7) community and environmental health;
- 8           (8) mental and emotional health;
- 9           (9) parenting and the challenges of raising chil-
- 10       dren; and
- 11           (10) the effective use of the health services de-
- 12       livery system.

13       (e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH  
 14       EDUCATION.—The Secretary shall establish within the Of-  
 15       fice of the Secretary an Office of Comprehensive School  
 16       Health Education which shall have the following respon-  
 17       sibilities:

- 18           (1) To recommend mechanisms for the coordi-  
 19       nation of school health education programs con-  
 20       ducted by the various departments and agencies of  
 21       the Federal Government.
- 22           (2) To advise the Secretary on formulation of  
 23       school health education policy within the Depart-  
 24       ment of Education.

1           (3) To disseminate information on the benefits  
 2       to health education of utilizing a comprehensive  
 3       health curriculum in schools.

4       (f) AUTHORIZATION OF APPROPRIATIONS.—

5           (1) IN GENERAL.—There are authorized to be  
 6       appropriated \$50,000,000 for fiscal year 2002 and  
 7       such sums as may be necessary for each of the fiscal  
 8       years 2003 and 2004 to carry out this section.

9           (2) AVAILABILITY.—Funds appropriated pursu-  
 10      ant to the authority of paragraph (1) in any fiscal  
 11      year shall remain available for obligation and ex-  
 12      penditure until the end of the fiscal year succeeding  
 13      the fiscal year for which such funds were appro-  
 14      priated.

15   **SEC. 505. COMPREHENSIVE EARLY CHILDHOOD HEALTH**  
 16                           **EDUCATION PROGRAM.**

17       (a) PURPOSE.—It is the purpose of this section to  
 18      establish a comprehensive early childhood health education  
 19      program.

20       (b) PROGRAM.—The Secretary of Health and Human  
 21      Services (referred to in this section as the “Secretary”)  
 22      shall conduct a program of awarding grants to agencies  
 23      conducting Head Start training to enable such agencies  
 24      to provide training and technical assistance to Head Start

1 teachers and other child care providers. Such program  
2 shall—

3           (1) establish a training system through the  
4       Head Start agencies and organizations conducting  
5       Head Start training for the purpose of enhancing  
6       teacher skills and providing comprehensive early  
7       childhood health education curriculum;

8           (2) enable such agencies and organizations to  
9       provide training to day care providers in order to  
10      strengthen the skills of the early childhood workforce  
11      in providing health education;

12          (3) provide technical support for health edu-  
13      cation programs and curricula; and

14          (4) provide cooperation with other early child-  
15      hood providers to ensure coordination of such pro-  
16      grams and the transition of students into the public  
17      school environment.

18      (c) USE OF FUNDS.—Grant funds under this section  
19      may be used to provide training and technical assistance  
20      in the areas of—

21           (1) personal health and fitness;

22           (2) prevention of chronic diseases;

23           (3) prevention and control of communicable dis-  
24      eases;

25           (4) dental health;



- 1           (5) nutrition;
- 2           (6) substance use and abuse;
- 3           (7) accident prevention and safety;
- 4           (8) community and environmental health;
- 5           (9) mental and emotional health; and
- 6           (10) strengthening the role of parent involve-
- 7           ment.

8           (d) RESERVATION FOR INNOVATIVE PROGRAMS.—

9   The Secretary shall reserve 5 percent of the funds appro-

10   priated pursuant to the authority of subsection (e) in each

11   fiscal year for the development of innovative model health

12   education programs or curricula.

13          (e) AUTHORIZATION OF APPROPRIATIONS.—There

14   are authorized to be appropriated \$40,000,000 for fiscal

15   year 2002 and such sums as may be necessary for each

16   of the fiscal years 2003 and 2004 to carry out this section.

17   **SEC. 506. ADOLESCENT FAMILY LIFE AND ABSTINENCE.**

18          (a) DEFINITIONS.—Section 2002(a)(4)(G)(i) of the

19   Public Health Service Act (42 U.S.C. 300z–1(a)(4)(G)(i))

20   is amended by inserting “and abstinence” after “adop-

21   tion”.

22          (b) GEOGRAPHIC DIVERSITY.—Section 2005 of the

23   Public Health Service Act (42 U.S.C. 300z–4) is

24   amended—

1           (1) by redesignating subsections (b) and (c) as  
2           subsections (c) and (d), respectively; and

3           (2) by inserting after subsection (a) the fol-  
4           lowing:

5           “(b) In approving applications for grants for dem-  
6           onstration projects for services under this title, the Sec-  
7           retary shall, to the maximum extent practicable, ensure  
8           adequate representation of both urban and rural areas.”.

9           (c) SIMPLIFIED APPLICATION PROCESS.—Section  
10          2006 of the Public Health Service Act (42 U.S.C. 300z–  
11          5) is amended by adding at the end following:

12          “(g) The Secretary shall develop and implement a  
13          simplified and expedited application process for applicants  
14          seeking less than \$15,000 of funds available under this  
15          title for a demonstration project.”.

16          (d) AUTHORIZATION OF APPROPRIATIONS.—Section  
17          2010(a) of the Public Health Service Act (42 U.S.C.  
18          300z–9) is amended to read as follows:

19          “(a) For the purpose of carrying out this title, there  
20          are authorized to be appropriated \$75,000,000 for each  
21          of the fiscal years 2002 through 2006.”.

1 **TITLE VI—PATIENT’S RIGHT TO**  
2 **DECLINE MEDICAL TREATMENT**

3 **SEC. 601. PATIENT’S RIGHT TO DECLINE MEDICAL TREAT-**  
4 **MENT.**

5 (a) RIGHT TO DECLINE MEDICAL TREATMENT.—

6 (1) RIGHTS OF COMPETENT ADULTS.—

7 (A) IN GENERAL.—Except as provided in  
8 subparagraph (B), a State may not restrict the  
9 right of a competent adult to consent to, or to  
10 decline, medical treatment.

11 (B) LIMITATIONS.—

12 (i) AFFECT ON THIRD PARTIES.—A  
13 State may impose limitations on the right  
14 of a competent adult to decline treatment  
15 if such limitations protect third parties (in-  
16 cluding minor children) from harm.

17 (ii) TREATMENT WHICH IS NOT MEDI-  
18 CALLY INDICATED.—Nothing in this sub-  
19 section shall be construed to require that  
20 any individual be offered, or to state that  
21 any individual may demand, medical treat-  
22 ment which the health care provider does  
23 not have available, or which is, under pre-  
24 vailing medical standards, either futile or  
25 otherwise not medically indicated.

1 (2) RIGHTS OF INCAPACITATED ADULTS.—

2 (A) IN GENERAL.—Except as provided in  
 3 subparagraph (B)(i) of paragraph (1), States  
 4 may not restrict the right of an incapacitated  
 5 adult to consent to, or to decline, medical treat-  
 6 ment as exercised through the documents speci-  
 7 fied in this paragraph, or through similar docu-  
 8 ments or other written methods of directive  
 9 which evidence the adult’s treatment choices.

10 (B) ADVANCE DIRECTIVES AND POWERS  
 11 OF ATTORNEY.—

12 (i) IN GENERAL.—In order to facili-  
 13 tate the communication, despite incapacity,  
 14 of an adult’s treatment choices, the Sec-  
 15 retary of Health and Human Services (re-  
 16 ferred to in this section as the “Sec-  
 17 retary”), in consultation with the Attorney  
 18 General, shall develop a national advance  
 19 directive form that—

20 (I) shall not limit or otherwise  
 21 restrict, except as provided in sub-  
 22 paragraph (B)(i) of paragraph (1), an  
 23 adult’s right to consent to, or to de-  
 24 cline, medical treatment; and

25 (II) shall, at minimum—

1           (aa) provide the means for  
 2           an adult to declare such adult's  
 3           own treatment choices in the  
 4           event of a terminal condition;

5           (bb) provide the means for  
 6           an adult to declare, at such  
 7           adult's option, treatment choices  
 8           in the event of other conditions  
 9           which are medically incurable,  
 10          and from which such adult likely  
 11          will not recover; and

12          (cc) provide the means by  
 13          which an adult may, at such  
 14          adult's option, declare such  
 15          adult's wishes with respect to all  
 16          forms of medical treatment, in-  
 17          cluding forms of medical treat-  
 18          ment such as the provision of nu-  
 19          trition and hydration by artificial  
 20          means which may be, in some cir-  
 21          cumstances, relatively nonburden-  
 22          some.

23           (ii) NATIONAL DURABLE POWER OF  
 24           ATTORNEY FORM.—The Secretary, in con-  
 25           sultation with the Attorney General, shall

1 develop a national durable power of attor-  
 2 ney form for health care decisionmaking.  
 3 The form shall provide a means for any  
 4 adult to designate another adult or adults  
 5 to exercise the same decisionmaking pow-  
 6 ers which would otherwise be exercised by  
 7 the patient if the patient were competent.

8 (iii) HONORED BY ALL HEALTH CARE  
 9 PROVIDERS.—The national advance direc-  
 10 tive and durable power of attorney forms  
 11 developed by the Secretary shall be hon-  
 12 ored by all health care providers.

13 (iv) LIMITATIONS.—No individual  
 14 shall be required to execute an advance di-  
 15 rective. This section makes no presumption  
 16 concerning the intention of an individual  
 17 who has not executed an advance directive.  
 18 An advance directive shall be sufficient,  
 19 but not necessary, proof of an adult's  
 20 treatment choices with respect to the cir-  
 21 cumstances addressed in the advance direc-  
 22 tive.

23 (C) DEFINITION.—For purposes of this  
 24 paragraph, the term “incapacity” means the in-  
 25 ability to understand or to communicate con-

cerning the nature and consequences of a health care decision (including the intended benefits and foreseeable risks of, and alternatives to, proposed treatment options), and to reach an informed decision concerning health care.

(3) HEALTH CARE PROVIDERS.—

(A) IN GENERAL.—No health care provider may provide treatment to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form or another written method of directive which clearly and convincingly evidence the adult's treatment choices. A health care provider who acts in good faith pursuant to the preceding sentence shall be immune from criminal or civil liability or discipline for professional misconduct.

(B) HEALTH CARE PROVIDERS UNDER THE MEDICARE AND MEDICAID PROGRAMS.—

Any health care provider who knowingly provides services to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form

1 or another written method of directive which  
2 clearly and convincingly evidence the adult's  
3 treatment choices, shall be denied payment for  
4 such services under titles XVIII and XIX of the  
5 Social Security Act.

6 (C) TRANSFERS.—Health care providers  
7 who object to the provision of medical care in  
8 accordance with an adult's wishes shall transfer  
9 the adult to the care of another health care pro-  
10 vider.

11 (4) DEFINITION.—For purposes of this sub-  
12 section, the term “adult” means—

13 (A) an individual who is 18 years of age or  
14 older; or

15 (B) an emancipated minor.

16 (b) FEDERAL RIGHT ENFORCEABLE IN FEDERAL  
17 COURTS.—The rights recognized in this section may be  
18 enforced by filing a civil action in an appropriate district  
19 court of the United States.

20 (c) SUICIDE AND HOMICIDE.—Nothing in this section  
21 shall be construed to permit, condone, authorize, or ap-  
22 prove suicide or mercy killing, or any affirmative act to  
23 end a human life.



1 (d) RIGHTS GRANTED BY STATES.—Nothing in this  
 2 section shall impair or supersede rights granted by State  
 3 law which exceed the rights recognized by this section.

4 (e) EFFECT ON OTHER LAWS.—

5 (1) IN GENERAL.—Except as specified in para-  
 6 graph (2), written policies and written information  
 7 adopted by health care providers pursuant to sec-  
 8 tions 4206 and 4751 of the Omnibus Budget Rec-  
 9 onciliation Act of 1990 (Public Law 101–508), shall  
 10 be modified within 6 months after the enactment of  
 11 this section to conform to the provisions of this sec-  
 12 tion.

13 (2) DELAY PERIOD FOR UNIFORM FORMS.—  
 14 Health care providers shall modify any written forms  
 15 distributed as written information under sections  
 16 4206 and 4751 of the Omnibus Budget Reconcili-  
 17 ation Act of 1990 (Public Law 101–508) not later  
 18 than 6 months after promulgation of the forms re-  
 19 ferred to in clauses (i) and (ii) of subsection  
 20 (a)(2)(B) by the Secretary.

21 (f) INFORMATION PROVIDED TO CERTAIN INDIVID-  
 22 UALS.—The Secretary shall provide on a periodic basis  
 23 written information regarding an individual’s right to con-  
 24 sent to, or to decline, medical treatment as provided in

1 this section to individuals who are beneficiaries under ti-  
 2 tles II, XVI, XVIII, and XIX of the Social Security Act.

3 (g) RECOMMENDATIONS TO CONGRESS ON ISSUES  
 4 RELATING TO A PATIENT’S RIGHT OF SELF-DETERMINA-  
 5 TION.—Not later than 180 days after the date of the en-  
 6 actment of this Act, and annually thereafter for a period  
 7 of 3 years, the Secretary shall provide recommendations  
 8 to Congress concerning the medical, legal, ethical, social,  
 9 and educational issues related to in this section. In devel-  
 10 oping recommendations under this subsection the Sec-  
 11 retary shall address the following issues:

12 (1) The contents of the forms referred to in  
 13 clauses (i) and (ii) of subsection (a)(2)(B).

14 (2) Issues pertaining to the education and  
 15 training of health care professionals concerning pa-  
 16 tients’ self-determination rights.

17 (3) Issues pertaining to health care profes-  
 18 sionals’ duties with respect to patients’ rights, and  
 19 health care professionals’ roles in identifying, assess-  
 20 ing, and presenting for patient consideration medi-  
 21 cally indicated treatment options.

22 (4) Issues pertaining to the education of pa-  
 23 tients concerning their rights to consent to, and de-  
 24 cline, treatment, including how individuals might  
 25 best be informed of such rights prior to hospitaliza-

tion and how uninsured individuals, and individuals not under the regular care of a physician or another provider, might best be informed of their rights.

(5) Issues relating to appropriate standards to be adopted concerning decisionmaking by incapacitated adult patients whose treatment choices are not known.

(6) Such other issues as the Secretary may identify.

(h) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section shall take effect on the date that is 6 months after the date of enactment of this Act.

(2) SUBSECTION (g).—The provisions of subsection (g) shall take effect on the date of enactment of this Act.

## **TITLE VII—PRIMARY AND PREVENTIVE CARE PROVIDERS**

### **SEC. 701. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.**

(a) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C.

1 1395l(a)(1)(O)) is amended by striking “85 percent” and  
 2 inserting “90 percent” each place it appears.

3 (b) TECHNICAL AMENDMENT.—Section  
 4 1833(a)(1)(O) of the Social Security Act (42 U.S.C.  
 5 1395l(a)(1)(O)) is amended by striking “clinic” and in-  
 6 serting “clinical”.

7 (c) EFFECTIVE DATE.—The amendments made by  
 8 this section shall apply with respect to services furnished  
 9 and supplies provided on and after January 1, 2002.

10 **SEC. 702. REQUIRING COVERAGE OF CERTAIN NONPHYSI-**  
 11 **CIAN PROVIDERS UNDER THE MEDICAID**  
 12 **PROGRAM.**

13 (a) IN GENERAL.—Section 1905(a) of the Social Se-  
 14 curity Act (42 U.S.C. 1396d(a)), as amended by section  
 15 301(c)(1), is amended—

16 (1) in paragraph (27), by striking “and” at the  
 17 end;

18 (2) by redesignating paragraph (28) as para-  
 19 graph (29); and

20 (3) by inserting after paragraph (27) the fol-  
 21 lowing:

22 “(28) services furnished by a physician assist-  
 23 ant, nurse practitioner, clinical nurse specialist (as  
 24 defined in section 1861(aa)(5)), or certified reg-

1        istered nurse anesthetist (as defined in section  
2        1861(bb)(2)); and”.

3        (b)        CONFORMING        AMENDMENT.—Section  
4        1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C.  
5        1396a(a)(10)(C)(iv)), as amended by section 301(c)(3), is  
6        amended by striking “and (27)” and inserting “, (27), and  
7        (28)”.

8        (c) EFFECTIVE DATE.—The amendments made by  
9        this section shall apply to medical assistance furnished  
10       under title XIX of the Social Security Act (42 U.S.C.  
11       1396 et seq.) beginning with the first fiscal year quarter  
12       that begins after the date of enactment of this Act.

13       **SEC. 703. MEDICAL STUDENT TUTORIAL PROGRAM**  
14       **GRANTS.**

15       Part C of title VII of the Public Health Service Act  
16       (42 U.S.C. 293j et seq.) is amended by adding at the end  
17       thereof the following:

18       **“SEC. 749. MEDICAL STUDENT TUTORIAL PROGRAM**  
19       **GRANTS.**

20       “(a) ESTABLISHMENT.—The Secretary shall estab-  
21       lish a program to award grants to eligible schools of medi-  
22       cine or osteopathic medicine to enable such schools to pro-  
23       vide medical students for tutorial programs or as partici-  
24       pants in clinics designed to interest high school or college  
25       students in careers in general medical practice.

1       “(b) APPLICATION.—To be eligible to receive a grant  
 2 under this section, a school of medicine or osteopathic  
 3 medicine shall prepare and submit to the Secretary an ap-  
 4 plication at such time, in such manner, and containing  
 5 such information as the Secretary may require, including  
 6 assurances that the school will use amounts received under  
 7 the grant in accordance with subsection (c).

8       “(c) USE OF FUNDS.—

9               “(1) IN GENERAL.—Amounts received under a  
 10 grant awarded under this section shall be used to—

11                   “(A) fund programs under which students  
 12 of the grantee are provided as tutors for high  
 13 school and college students in the areas of  
 14 mathematics, science, health promotion and  
 15 prevention, first aid, nutrition and prenatal  
 16 care;

17                   “(B) fund programs under which students  
 18 of the grantee are provided as participants in  
 19 clinics and seminars in the areas described in  
 20 paragraph (1); and

21                   “(C) conduct summer institutes for high  
 22 school and college students to promote careers  
 23 in medicine.

1           “(2) DESIGN OF PROGRAMS.—The programs,  
2           institutes, and other activities conducted by grantees  
3           under paragraph (1) shall be designed to—

4                   “(A) give medical students desiring to  
5                   practice general medicine access to the local  
6                   community;

7                   “(B) provide information to high school  
8                   and college students concerning medical school  
9                   and the general practice of medicine; and

10                   “(C) promote careers in general medicine.

11           “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
12           are authorized to be appropriated to carry out this section,  
13           \$5,000,000 for fiscal year 2002, and such sums as may  
14           be necessary for fiscal year 2003.”.

15   **SEC. 704. GENERAL MEDICAL PRACTICE GRANTS.**

16           Part C of title VII of the Public Health Service Act  
17           (as amended by section 703) is further amended by adding  
18           at the end thereof the following:

19   **“SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.**

20                   “(a) ESTABLISHMENT.—The Secretary shall estab-  
21                   lish a program to award grants to eligible public or private  
22                   nonprofit schools of medicine or osteopathic medicine, hos-  
23                   pitals, residency programs in family medicine or pediat-  
24                   rics, or to a consortium of such entities, to enable such  
25                   entities to develop effective strategies for recruiting med-

1 ical students interested in the practice of general medicine  
2 and placing such students into general practice positions  
3 upon graduation.

4 “(b) APPLICATION.—To be eligible to receive a grant  
5 under this section, an entity of the type described in sub-  
6 section (a) shall prepare and submit to the Secretary an  
7 application at such time, in such manner, and containing  
8 such information as the Secretary may require, including  
9 assurances that the entity will use amounts received under  
10 the grant in accordance with subsection (c).

11 “(c) USE OF FUNDS.—Amounts received under a  
12 grant awarded under this section shall be used to fund  
13 programs under which effective strategies are developed  
14 and implemented for recruiting medical students inter-  
15 ested in the practice of general medicine and placing such  
16 students into general practice positions upon graduation.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
18 are authorized to be appropriated to carry out this section,  
19 \$25,000,000 for each of the fiscal years 2002 through  
20 2004, and such sums as may be necessary for fiscal years  
21 thereafter.”.



1 **TITLE VIII—SAFE AND COST-EF-**  
 2 **FECTIVE MEDICAL TREAT-**  
 3 **MENT**

4 **SEC. 801. ENHANCING INVESTMENT IN COST-EFFECTIVE**  
 5 **METHODS OF HEALTH CARE.**

6 (a) ESTABLISHMENT OF TRUST FUND FOR MEDICAL  
 7 TREATMENT OUTCOMES RESEARCH.—

8 (1) IN GENERAL.—Subchapter A of chapter 98  
 9 of the Internal Revenue Code of 1986 (relating to  
 10 trust fund code) is amended by adding at the end  
 11 the following:

12 **“SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUT-**  
 13 **COMES RESEARCH.**

14 “(a) CREATION OF TRUST FUND.—There is estab-  
 15 lished in the Treasury of the United States a trust fund  
 16 to be known as the ‘Trust Fund for Medical Treatment  
 17 Outcomes Research’ (referred to in this section as the  
 18 ‘Trust Fund’), consisting of such amounts as may be ap-  
 19 propriated or credited to the Trust Fund as provided in  
 20 this section or section 9602(b).

21 “(b) TRANSFERS TO TRUST FUND.—There is hereby  
 22 appropriated to the Trust Fund an amount equivalent to  
 23 the taxes received in the Treasury under section 4491 (re-  
 24 lating to tax on health insurance policies).

1       “(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—  
 2   On an annual basis and without further appropriation the  
 3   Secretary shall distribute the amounts in the Trust Fund  
 4   to the Secretary of Health and Human Services for use  
 5   by the Agency for Healthcare Research and Quality. Such  
 6   amounts shall be available to pay for research activities  
 7   related to medical treatment outcomes and shall be in ad-  
 8   dition to any other amounts appropriated for such pur-  
 9   poses.”.

10           (2) CONFORMING AMENDMENT.—The table of  
 11       sections for subchapter A of chapter 98 of such  
 12       Code is amended by adding at the end the following:

“Sec. 9511. Trust Fund for Medical Treatment Outcomes Re-  
 search.”.

13       (b) IMPOSITION OF TAX ON HEALTH INSURANCE  
 14   POLICIES.—

15           (1) IN GENERAL.—Chapter 36 of the Internal  
 16       Revenue Code of 1986 (relating to certain other ex-  
 17       cise taxes) is amended by adding at the end the fol-  
 18       lowing:

19       **“Subchapter F—Tax on Health Insurance**  
 20       **Policies**

“Sec. 4491. Imposition of tax.  
 “Sec. 4492. Liability for tax.

21   **“SEC. 4491. IMPOSITION OF TAX.**

22       “(a) GENERAL RULE.—There is hereby imposed a  
 23   tax equal to .001 cent on each dollar, or fractional part

1 thereof, of the premium paid on a policy of health insur-  
 2 ance.

3 “(b) DEFINITION.—For purposes of subsection (a),  
 4 the term ‘policy of health insurance’ means any policy or  
 5 other instrument by whatever name called whereby a con-  
 6 tract of insurance is made, continued, or renewed with re-  
 7 spect to the health of an individual or group of individuals.

8 **“SEC. 4492. LIABILITY FOR TAX.**

9 “The tax imposed by this subchapter shall be paid,  
 10 on the basis of a return, by any person who makes, signs,  
 11 issues, or sells any of the documents and instruments sub-  
 12 ject to the tax, or for whose use or benefit the same are  
 13 made, signed, issued, or sold. The United States or any  
 14 agency or instrumentality thereof shall not be liable for  
 15 the tax.”.

16 (2) CONFORMING AMENDMENT.—The table of  
 17 subchapters for chapter 36 of such Code is amended  
 18 by adding at the end the following:

“SUBCHAPTER F. Tax on health insurance policies.”.

19 (c) EFFECTIVE DATE.—The amendments made by  
 20 this section shall apply to policies issued after December  
 21 31, 2001.

22 **SEC. 802. MEDICAL ERRORS REDUCTION.**

23 Title IX of the Public Health Service Act (42 U.S.C.  
 24 299 et seq.) is amended—

25 (1) by redesignating part C as part D;

1           (2) by redesignating sections 921 through 928,  
2           as sections 931 through 938, respectively;

3           (3) in section 938(1) (as so redesignated), by  
4           striking “921” and inserting “931”; and

5           (4) by inserting after part B the following:

6       **“PART C—REDUCING ERRORS IN HEALTH CARE**

7       **“SEC. 921. DEFINITIONS.**

8           “In this part:

9           “(1) ADVERSE EVENT.—The term ‘adverse  
10          event’ means an injury resulting from medical man-  
11          agement rather than the underlying condition of the  
12          patient.

13          “(2) ERROR.—The term ‘error’ means the fail-  
14          ure of a planned action to be completed as intended  
15          or the use of a wrong plan to achieve the desired  
16          outcome.

17          “(3) HEALTH CARE PROVIDER.—The term  
18          ‘health care provider’ means an individual or entity  
19          that provides medical services and is a participant in  
20          a demonstration program under this part.

21          “(4) HEALTH CARE-RELATED ERROR.—The  
22          term “health care-related error” means a prevent-  
23          able adverse event related to a health care interven-  
24          tion or a failure to intervene appropriately.

1 “(5) MEDICATION-RELATED ERROR.—The term  
 2 ‘medication-related error’ means a preventable ad-  
 3 verse event related to the administration of a medi-  
 4 cation.

5 “(6) SAFETY.—The term ‘safety’ with respect  
 6 to an individual means that such individual has a  
 7 right to be free from preventable serious injury.

8 “(7) SENTINEL EVENT.—The term ‘sentinel  
 9 event’ means an unexpected occurrence involving an  
 10 individual that results in death or serious physical  
 11 injury that is unrelated to the natural course of the  
 12 individual’s illness or underlying condition.

13 **“SEC. 922. ESTABLISHMENT OF STATE-BASED MEDICAL**  
 14 **ERROR REPORTING SYSTEMS.**

15 “(a) IN GENERAL.—The Secretary shall make grants  
 16 available to States to enable such States to establish re-  
 17 porting systems designed to reduce medical errors and im-  
 18 prove health care quality.

19 “(b) REQUIREMENT.—

20 “(1) IN GENERAL.—To be eligible to receive a  
 21 grant under subsection (a), the State involved shall  
 22 provide assurances to the Secretary that amounts re-  
 23 ceived under the grant will be used to establish and  
 24 implement a medical error reporting system using  
 25 guidelines (including guidelines relating to the con-

1        confidentiality of the reporting system) developed by the  
2        Agency for Healthcare Research and Quality with  
3        input from interested, non-governmental parties in-  
4        cluding patient, consumer and health care provider  
5        groups.

6            “(2) GUIDELINES.—Not later than 90 days  
7        after the date of enactment of this part, the Agency  
8        for Healthcare Research and Quality shall develop  
9        and publish the guidelines described in paragraph  
10       (1).

11       “(c) DATA.—

12            “(1) AVAILABILITY.—A State that receives a  
13        grant under subsection (a) shall make the data pro-  
14        vided to the medical error reporting system involved  
15        available only to the Agency for Healthcare Research  
16        and Quality and may not otherwise disclose such in-  
17        formation.

18            “(2) CONFIDENTIALITY.—Nothing in this part  
19        shall be construed to supersede any State law that  
20        is inconsistent with this part.

21       “(d) APPLICATION.—To be eligible for a grant under  
22       this section, a State shall prepare and submit to the Sec-  
23       retary an application at such time, in such manner and  
24       containing, such information as the Secretary shall re-  
25       quire.

1 **“SEC. 923. DEMONSTRATION PROJECTS TO REDUCE MED-**  
2 **ICAL ERRORS, IMPROVE PATIENT SAFETY,**  
3 **AND EVALUATE REPORTING.**

4 “(a) ESTABLISHMENT.—The Secretary, acting  
5 through the Director of the Agency for Healthcare Re-  
6 search and Quality and in conjunction with the Adminis-  
7 trator of the Health Care Financing Administration, may  
8 establish a program under which funding will be provided  
9 for not less than 15 demonstration projects, to be competi-  
10 tively awarded, in health care facilities and organizations  
11 in geographically diverse locations, including rural and  
12 urban areas (as determined by the Secretary), to deter-  
13 mine the causes of medical errors and to—

14 “(1) use technology, staff training, and other  
15 methods to reduce such errors;

16 “(2) develop replicable models that minimize  
17 the frequency and severity of medical errors;

18 “(3) develop mechanisms that encourage report-  
19 ing, prompt review, and corrective action with re-  
20 spect to medical errors; and

21 “(4) develop methods to minimize any addi-  
22 tional paperwork burden on health care profes-  
23 sionals.

24 “(b) ACTIVITIES.—

1           “(1) IN GENERAL.—A health care provider par-  
2       ticipating in a demonstration project under sub-  
3       section (a) shall—

4           “(A) utilize all available and appropriate  
5       technologies to reduce the probability of future  
6       medical errors; and

7           “(B) carry out other activities consistent  
8       with subsection (a).

9           “(2) REPORTING TO PATIENTS.—In carrying  
10      out this section, the Secretary shall ensure that—

11          “(A) 5 of the demonstration projects per-  
12      mit the voluntary reporting by participating  
13      health care providers of any adverse events,  
14      sentinel events, health care-related errors, or  
15      medication-related errors to the Secretary;

16          “(B) 5 of the demonstration projects re-  
17      quire participating health care providers to re-  
18      port any adverse events, sentinel events, health  
19      care-related errors, or medication-related errors  
20      to the Secretary; and

21          “(C) 5 of the demonstration projects re-  
22      quire participating health care providers to re-  
23      port any adverse events, sentinel events, health  
24      care-related errors, or medication-related errors



1 to the Secretary and to the patient involved and  
2 a family member or guardian of the patient.

3 “(3) CONFIDENTIALITY.—

4 “(A) IN GENERAL.—The Secretary and the  
5 participating grantee organization shall ensure  
6 that information reported under this section re-  
7 mains confidential.

8 “(B) USE.—The Secretary may use the in-  
9 formation reported under this section only for  
10 the purpose of evaluating the ability to reduce  
11 errors in the delivery of care. Such information  
12 shall not be used for enforcement purposes.

13 “(C) DISCLOSURE.—The Secretary may  
14 not disclose the information reported under this  
15 section.

16 “(D) NONADMISSIBILITY.—Information re-  
17 ported under this section shall be privileged,  
18 confidential, shall not be admissible as evidence  
19 or discoverable in any civil or criminal action or  
20 proceeding or subject to disclosure, and shall  
21 not be subject to the Freedom of Information  
22 Act (5 U.S.C. App). This paragraph shall apply  
23 to all information maintained by the reporting  
24 entity and the entities who receive such reports.

1       “(c) USE OF TECHNOLOGIES.—The Secretary shall  
 2 encourage, as part of the demonstration projects con-  
 3 ducted under subsection (a), the use of appropriate tech-  
 4 nologies to reduce medical errors, such as hand-held elec-  
 5 tronic prescription pads, training simulators for medical  
 6 education, and bar-coding of prescription drugs and pa-  
 7 tient bracelets.

8       “(d) DATABASE.—The Secretary shall provide for the  
 9 establishment and operation of a national database of  
 10 medical errors to be used as provided for by the Secretary.  
 11 The information provided to the Secretary under sub-  
 12 section (b)(2) shall be contained in the database.

13       “(e) EVALUATION.—The Secretary shall evaluate the  
 14 progress of each demonstration project established under  
 15 this section in reducing the incidence of medical errors and  
 16 submit the results of such evaluations as part of the re-  
 17 ports under section 926(b).

18       “(f) REPORTING.—Prior to October 1, of the third  
 19 fiscal year for which funds are made available under this  
 20 section, the Secretary shall prepare and submit to the ap-  
 21 propriate committees of Congress an interim report con-  
 22 cerning the results of such demonstration projects.

23       **“SEC. 924. PATIENT SAFETY IMPROVEMENT.**

24       “(a) IN GENERAL.—The Secretary shall provide in-  
 25 formation to educate patients and family members about

1 their role in reducing medical errors. Such information  
 2 shall be provided to all individuals who participate in Fed-  
 3 erally-funded health care programs.

4 “(b) DEVELOPMENT OF PROGRAMS.—The Secretary  
 5 shall develop programs that encourage patients to take a  
 6 more active role in their medical treatment, including en-  
 7 couraging patients to provide information to health care  
 8 providers concerning pre-existing conditions and medica-  
 9 tions.

10 **“SEC. 925. PRIVATE, NONPROFIT EFFORTS TO REDUCE**  
 11 **MEDICAL ERRORS.**

12 “(a) IN GENERAL.—The Secretary shall make grants  
 13 to health professional associations and other organizations  
 14 to provide training in ways to reduce medical errors, in-  
 15 cluding curriculum development, technology training, and  
 16 continuing medical education.

17 “(b) APPLICATION.—To be eligible for a grant under  
 18 this section, an entity shall prepare and submit to the Sec-  
 19 retary an application at such time, in such manner and  
 20 containing, such information as the Secretary shall re-  
 21 quire.

22 **“SEC. 926. REPORT TO CONGRESS.**

23 “(a) INITIAL REPORT.—Not later than 180 days  
 24 after the date of enactment of this part, the Secretary  
 25 shall prepare and submit to the appropriate committees

1 of Congress a report concerning the costs associated with  
2 implementing a program that identifies factors that con-  
3 tribute to errors and which includes upgrading the health  
4 care computer systems and other technologies in the  
5 United States in order to reduce medical errors, including  
6 computerizing hospital systems for the coordination of  
7 prescription drugs and handling of laboratory specimens,  
8 and contains recommendation on ways in which to reduce  
9 those factors.

10 “(b) OTHER REPORTS.—Not later than 180 days  
11 after the completion of all demonstration projects under  
12 section 923, the Secretary shall prepare and submit to the  
13 appropriate committees of Congress a report concerning—

14 “(1) how successful each demonstration project  
15 was in reducing medical errors;

16 “(2) the data submitted by States under section  
17 922(c);

18 “(3) the best methods for reducing medical er-  
19 rors;

20 “(4) the costs associated with applying such  
21 best methods on a nationwide basis; and

22 “(5) the manner in which other Federal agen-  
23 cies can share information on best practices in order  
24 to reduce medical errors in all Federal health care  
25 programs.

1 **“SEC. 927. AUTHORIZATION OF APPROPRIATIONS.**

2 “There is authorized to be appropriated such sums  
3 as may be necessary to carry out this part.”.

4 **TITLE IX—TAX INCENTIVES FOR**  
5 **PURCHASE OF QUALIFIED**  
6 **LONG-TERM CARE INSUR-**  
7 **ANCE**

8 **SEC. 901. CREDIT FOR QUALIFIED LONG-TERM CARE PRE-**  
9 **MIUMS.**

10 (a) GENERAL RULE.—Subpart C of part IV of sub-  
11 chapter A of chapter 1 of the Internal Revenue Code of  
12 1986 (relating to refundable credits) is amended by redes-  
13 ignating section 35 as section 36 and by inserting after  
14 section 34 the following:

15 **“SEC. 35. LONG-TERM CARE INSURANCE CREDIT.**

16 “(a) GENERAL RULE.—In the case of an individual,  
17 there shall be allowed as a credit against the tax imposed  
18 by this subtitle for the taxable year an amount equal to  
19 the applicable percentage of the premiums for a qualified  
20 long-term care insurance contract (as defined in section  
21 7702B(b)) paid during such taxable year for such indi-  
22 vidual or the spouse of such individual.

23 “(b) APPLICABLE PERCENTAGE.—

24 “(1) IN GENERAL.—For purposes of this sec-  
25 tion, the term ‘applicable percentage’ means 28 per-  
26 cent reduced (but not below zero) by 1 percentage

1 point for each \$1,000 (or fraction thereof) by which  
 2 the taxpayer's adjusted gross income for the taxable  
 3 year exceeds the base amount.

4 “(2) BASE AMOUNT.—For purposes of para-  
 5 graph (1) the term ‘base amount’ means—

6 “(A) except as otherwise provided in this  
 7 paragraph, \$25,000,

8 “(B) \$40,000 in the case of a joint return,  
 9 and

10 “(C) zero in the case of a taxpayer who—

11 “(i) is married at the close of the tax-  
 12 able year (within the meaning of section  
 13 7703) but does not file a joint return for  
 14 such taxable year, and

15 “(ii) does not live apart from the tax-  
 16 payer's spouse at all times during the tax-  
 17 able year.

18 “(c) COORDINATION WITH MEDICAL EXPENSE DE-  
 19 Duction.—Any amount allowed as a credit under this  
 20 section shall not be taken into account under section  
 21 213.”.

22 (b) CONFORMING AMENDMENT.—The table of sec-  
 23 tions for such subpart C is amended by striking the item  
 24 relating to section 35 and inserting the following:

“Sec. 35. Long-term care insurance credit.  
 “Sec. 36. Overpayments of tax.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to taxable years beginning after  
 3 December 31, 2001.

4 **SEC. 902. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**  
 5 **SURANCE IN CAFETERIA PLANS AND FLEXI-**  
 6 **BLE SPENDING ARRANGEMENTS.**

7 (a) CAFETERIA PLANS.—The last sentence of section  
 8 125(f) of the Internal Revenue Code of 1986 (defining  
 9 qualified benefits) is amended by striking “shall not” and  
 10 inserting “shall”.

11 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section  
 12 106(c) of the Internal Revenue Code of 1986 (relating to  
 13 contributions by employer to accident and health plans)  
 14 is amended—

15 (1) in paragraph (1), by striking “include” and  
 16 inserting “shall not”; and

17 (2) in the heading, by striking “INCLUSION”  
 18 and inserting “EXCLUSION”.

19 (c) EFFECTIVE DATE.—The amendments made by  
 20 this section shall apply to taxable years beginning after  
 21 December 31, 2000.

1 **SEC. 903. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**  
 2 **RECEIVED ON CANCELLATION OF LIFE IN-**  
 3 **SURANCE POLICIES AND USED FOR QUALI-**  
 4 **FIED LONG-TERM CARE INSURANCE CON-**  
 5 **TRACTS.**

6 (a) IN GENERAL.—

7 (1) EXCLUSION FROM GROSS INCOME.—

8 (A) IN GENERAL.—Part III of subchapter  
 9 B of chapter 1 of the Internal Revenue Code of  
 10 1986 (relating to items specifically excluded  
 11 from gross income) is amended by redesign-  
 12 ating section 139 as section 140 and by insert-  
 13 ing after section 138 the following new section:

14 **“SEC. 139. AMOUNTS RECEIVED ON CANCELLATION, ETC.**  
 15 **OF LIFE INSURANCE CONTRACTS AND USED**  
 16 **TO PAY PREMIUMS FOR QUALIFIED LONG-**  
 17 **TERM CARE INSURANCE.**

18 “No amount (which but for this section would be in-  
 19 cludible in the gross income of an individual) shall be in-  
 20 cluded in gross income on the whole or partial surrender,  
 21 cancellation, or exchange of any life insurance contract  
 22 during the taxable year if—

23 “(1) such individual has attained age 59½ on  
 24 or before the date of the transaction, and

25 “(2) the amount otherwise includible in gross  
 26 income is used during such year to pay for any



1 qualified long-term care insurance contract (as de-  
 2 fined in section 7702B(b)) which—

3 “(A) is for the benefit of such individual or  
 4 the spouse of such individual if such spouse has  
 5 attained age 59½ on or before the date of the  
 6 transaction, and

7 “(B) may not be surrendered for cash.”.

8 (B) CONFORMING AMENDMENT.—The  
 9 table of sections for such part III is amended  
 10 by striking the item relating to section 139 and  
 11 inserting the following:

“Sec. 139. Amounts received on cancellation, etc. of life insurance  
 contracts and used to pay premiums for qualified  
 long-term care insurance.

“Sec. 140. Cross references to other Acts.”.

12 (2) CERTAIN EXCHANGES NOT TAXABLE.—Sec-  
 13 tion 1035(a) of such Code (relating to certain ex-  
 14 changes of insurance contracts) is amended by strik-  
 15 ing the period at the end of paragraph (3) and in-  
 16 serting “; or”, and by adding at the end the fol-  
 17 lowing:

18 “(4) in the case of an individual who has at-  
 19 tained age 59½, a contract of life insurance or an  
 20 endowment or annuity contract for a qualified long-  
 21 term care insurance contract (as defined in section  
 22 7702B(b)), if the qualified long-term care insurance  
 23 contract may not be surrendered for cash.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to taxable years beginning after  
 3 December 31, 2001.

4 **SEC. 904. USE OF GAIN FROM SALE OF PRINCIPAL RESI-**  
 5 **DENCE FOR PURCHASE OF QUALIFIED LONG-**  
 6 **TERM HEALTH CARE INSURANCE.**

7 (a) IN GENERAL.—Subsection (d) of section 121 of  
 8 the Internal Revenue Code of 1986 (relating to exclusion  
 9 of gain from sale of principal) is amended by adding at  
 10 the end the following:

11 “(9) ELIGIBILITY OF HOME EQUITY CONVER-  
 12 SION SALE-LEASEBACK TRANSACTION FOR EXCLU-  
 13 SION.—

14 “(A) IN GENERAL.—For purposes of this  
 15 section, the term ‘sale or exchange’ includes a  
 16 home equity conversion sale-leaseback trans-  
 17 action.

18 “(B) HOME EQUITY CONVERSION SALE-  
 19 LEASEBACK TRANSACTION.—For purposes of  
 20 subparagraph (A), the term ‘home equity con-  
 21 version sale-leaseback’ means a transaction in  
 22 which—

23 “(i) the seller-lessee—

24 “(I) sells property which during  
 25 the 5-year period ending on the date

1 of the transaction has been owned and  
2 used as a principal residence by such  
3 seller-lessee for periods aggregating 2  
4 years or more,

5 “(II) uses a portion of the pro-  
6 ceeds from such sale to purchase a  
7 qualified long-term care insurance  
8 contract (as defined in section  
9 7702B(b)), which contract may not be  
10 surrendered for cash,

11 “(III) obtains occupancy rights  
12 in such property pursuant to a written  
13 lease requiring a fair rental, and

14 “(IV) receives no option to repur-  
15 chase the property at a price less than  
16 the fair market price of the property  
17 unencumbered by any leaseback at the  
18 time such option is exercised, and

19 “(ii) the purchaser-lessor—

20 “(I) is a person,

21 “(II) is contractually responsible  
22 for the risks and burdens of owner-  
23 ship and receives the benefits of own-  
24 ership (other than the seller-lessee’s

1 occupancy rights) after the date of  
2 such transaction, and

3 “(III) pays a purchase price for  
4 the property that is not less than the  
5 fair market price of such property en-  
6 cumbered by a leaseback, and taking  
7 into account the terms of the lease.

8 “(C) ADDITIONAL DEFINITIONS.—For pur-  
9 poses of subparagraph (B)—

10 “(i) OCCUPANCY RIGHTS.—The term  
11 ‘occupancy rights’ means the right to oc-  
12 cupy the property for any period of time,  
13 including a period of time measured by the  
14 life of the seller-lessee on the date of the  
15 sale-leaseback transaction (or the life of  
16 the surviving seller-lessee, in the case of  
17 jointly held occupancy rights), or a periodic  
18 term subject to a continuing right of re-  
19 newal by the seller-lessee (or by the sur-  
20 viving seller-lessee, in the case of jointly  
21 held occupancy rights).

22 “(ii) FAIR RENTAL.—The term ‘fair  
23 rental’ means a rental for any subsequent  
24 year which equals or exceeds the rental for

1 the 1st year of a sale-leaseback trans-  
 2 action.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
 4 this section shall apply to sales after December 31, 2001,  
 5 in taxable years beginning after such date.

## 6 **TITLE X—NATIONAL FUND FOR** 7 **HEALTH RESEARCH**

### 8 **SEC. 1001. ESTABLISHMENT OF FUND.**

9 (a) ESTABLISHMENT.—There is established in the  
 10 Treasury of the United States a fund, to be known as the  
 11 “National Fund for Health Research” (in this section re-  
 12 ferred to as the “Fund”), consisting of such amounts as  
 13 are transferred to the Fund under subsection (b) and any  
 14 interest earned on investment of amounts in the Fund.

15 (b) TRANSFERS TO FUND.—

16 (1) IN GENERAL.—The Secretary of the Treas-  
 17 ury shall transfer to the Fund amounts equivalent to  
 18 amounts designated under paragraph (2) and re-  
 19 ceived in the Treasury.

20 (2) AMOUNTS.—

21 (A) HEALTH PLAN SET ASIDE.—With re-  
 22 spect to each calendar year beginning with the  
 23 first full calendar year after the date of enact-  
 24 ment of this Act, each health plan shall set

1           aside and transfer to the Treasury of the  
2           United States an amount equal to—

3                   (i) for the first full calendar year,  
4                   0.25 percent of all health premiums re-  
5                   ceived with respect to the plan for such  
6                   year;

7                   (ii) for the second full calendar year,  
8                   0.5 percent of all health premiums received  
9                   with respect to the plan for such year;

10                  (iii) for the third full calendar year,  
11                  0.75 percent of all health premiums re-  
12                  ceived with respect to the plan for such  
13                  year; and

14                  (iv) for the fourth and each suc-  
15                  ceeding full calendar year, 1 percent of all  
16                  health premiums received with respect to  
17                  the plan for such year.

18           (3) TRANSFERS BASED ON ESTIMATES.—The  
19           amounts transferred by paragraph (1) shall annually  
20           be transferred to the Fund within 30 days after the  
21           President signs an appropriations Act for the De-  
22           partments of Labor, Health and Human Services,  
23           and Education, and related agencies, or by the end  
24           of the first quarter of the fiscal year. Proper adjust-  
25           ment shall be made in amounts subsequently trans-

ferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(4) DEFINITION.—As used in this subsection, the term “health plan” means a group health plan (as defined in section 2791(a) of the Public Health Service Act and any individual health insurance (as defined in section 2791(b)(5) of such Act) operated by a health insurance issuer.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director’s discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women’s Health and the Office of Research on Minority Health, the Office of Rare Disease Research, the Office of Behavioral and Social Sciences

1 Research (for use for efforts to reduce to-  
2 bacco use), the Office of Dietary Supple-  
3 ments, and the Office for Disease Preven-  
4 tion; and

5 (ii) for construction and acquisition of  
6 equipment for or facilities of or used by  
7 the National Institutes of Health;

8 (B) 2 percent of such amounts for transfer  
9 to the National Center for Research Resources  
10 to carry out section 1502 of the National Insti-  
11 tutes of Health Revitalization Act of 1993 con-  
12 cerning Biomedical and Behavioral Research  
13 Facilities;

14 (C) 1 percent of such amounts during any  
15 fiscal year for carrying out section 301 and  
16 part D of title IV of the Public Health Service  
17 Act with respect to health information commu-  
18 nications; and

19 (D) the remainder of such amounts during  
20 any fiscal year to member institutes and cen-  
21 ters, including the Office of AIDS Research, of  
22 the National Institutes of Health in the same  
23 proportion to the total amount received under  
24 this section, as the amount of annual appro-  
25 priations under appropriations Acts for each



1 member institute and Centers for the fiscal year  
2 bears to the total amount of appropriations  
3 under appropriations Acts for all member insti-  
4 tutes and Centers of the National Institutes of  
5 Health for the fiscal year.

6 (2) PLANS OF ALLOCATION.—The amounts  
7 transferred under paragraph (1)(D) shall be allo-  
8 cated by the Director of the National Institutes of  
9 Health or the various directors of the institutes and  
10 centers, as the case may be, pursuant to allocation  
11 plans developed by the various advisory councils to  
12 such directors, after consultation with such direc-  
13 tors.

14 (3) GRANTS AND CONTRACTS FULLY FUNDED  
15 IN FIRST YEAR.—With respect to any grant or con-  
16 tract funded by amounts distributed under para-  
17 graph (1), the full amount of the total obligation of  
18 such grant or contract shall be funded in the first  
19 year of such grant or contract, and shall remain  
20 available until expended.

21 (4) TRIGGER AND RELEASE OF MONIES AND  
22 PHASE-IN.—

23 (A) TRIGGER AND RELEASE.—No expendi-  
24 ture shall be made under paragraph (1) during  
25 any fiscal year in which the annual amount ap-

1           appropriated for the National Institutes of Health  
2           is less than the amount so appropriated for the  
3           prior fiscal year.

4                   (B) PHASE-IN.—The Secretary of Health  
5           and Human Services shall phase-in the distribu-  
6           tions required under paragraph (1) so that—

7                           (i) 25 percent of the amount in the  
8           Fund is distributed in the first fiscal year  
9           for which funds are available;

10                          (ii) 50 percent of the amount in the  
11           Fund is distributed in the second fiscal  
12           year for which funds are available;

13                          (iii) 75 percent of the amount in the  
14           Fund is distributed in the third fiscal year  
15           for which funds are available; and

16                          (iv) 100 percent of the amount in the  
17           Fund is distributed in the fourth and each  
18           succeeding fiscal year for which funds are  
19           available.

20           (d) BUDGET TREATMENT OF AMOUNTS IN FUND.—

21   The amounts in the Fund shall be excluded from, and  
22   shall not be taken into account, for purposes of any budget  
23   enforcement procedure under the Congressional Budget

- 1 Act of 1974 or the Balanced Budget and Emergency Def-
- 2 icit Control Act of 1985.

